

**USAID/SENEGAL**

**HEALTH PROGRAM & STRATEGIC OPTIONS**  
**ASSESSMENT**

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**With**

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# USAID/SENEGAL HEALTH PROGRAM & STRATEGIC OPTIONS ASSESSMENT

## EXECUTIVE SUMMARY

USAID/Senegal is currently completing its FY 1998-2006 Country Strategic Plan, which includes strategic objectives (SOs) in private sector development, democracy and governance, health, and education, and a Casamance special objective to promote peace and economic development in that region. The Health SO for is *increased use of decentralized health services in targeted areas*. Health activities supports the goals and objectives of the Government of Senegal's (GOS) 1998 – 2007 National Plan for Health and Social Development, (PNDSS). USAID's current strategy ends in September 2006. In anticipation of continued involvement in the health sector, USAID contracted CRI Consult, Inc. to help USAID/Senegal determine whether its efforts in the health sector have been productive and successful, and to help guide the development of new directions in the next phase of USAID assistance to Senegal.

The USAID Health Strategy has contributed to impressive results in four technical domains: child survival, including malaria; maternal health/family planning; HIV/AIDS and sexually transmitted infections (STIs); and health financing. Although USAID Team initially hoped to obtain management efficiencies by minimizing the number of implementing partners, by March 2005 there were 15 cooperating agencies (CAs) working in the four technical domains, plus tuberculosis. These CAs collaborate with numerous GOS, NGO, private commercial, local government, and community actors throughout Senegal. Overall, about 55% of funding was allocated to more intensive decentralized services and systems in 21 health districts in five regions of Senegal, and about 45% of resources to national services and systems.

Overall, the strategy has achieved what it set out to do. USAID partners have nurtured community-local government-health service joint planning and budgeting in 150 communities in the 21 focus districts, resulting in upgraded equipment and infrastructure at numerous health centers and health posts. They have additionally collaborated with Ministry of Health (MOH) and regional and district colleagues to provide training and formative supervision integrate numerous service strategies into MOH norms and expand access to these new strategies to many health facilities in the focus districts.

Application of integrated management of childhood illnesses (IMCI) is now available in 72% of health facilities in focus regions, and intermittent presumptive therapy for malaria in pregnant women is available in 100%. Other new strategies in the process of development and/or integration include: community-based treatment of pneumonia; community-based presumptive treatment of malaria; a new neonatal care package; a new post-partum hemorrhage package; prevention of mother-to-child transmission of HIV, at all health centers; voluntary counseling and testing for HIV at all health centers; emergency obstetric care at health centers with operative capability; post-abortion care at hospitals and health centers with operative capability.

Through community, private sector, and public outlets, USAID partners sold more than 318,500 insecticide-treated bed nets (ITNs) and over 57,500 cycles of SECURIL oral contraceptives. USAID CAs helped strengthen mutual financing organizations to cover more than 44,000 beneficiaries.

Available data and interviews with key informants suggest that successes have been greater with services delivery (focus districts and nationwide) than with systems support in the current strategy. In hindsight, more attention to critical linkages between the local and national level

might have led to better communications between the local and national levels, and more widespread results.

To achieve these results, there has been significant GOS/MOH and USAID partnership in the implementation process at the national, regional, and district levels, particularly in the 21 focus regions. Given anticipated future increases in central revenue flows due to World Bank and European Union budget support and new Highly Indebted Poor Countries (HIPC) resources, there is no identified need for USAID to provide financial institutional support in the health sector. Given USAID's very high disbursement rates "off-budget," and the complex requirements associated with direct USAID funding, it is suggested that little benefit would accrue from such an effort. Subject to further discussion with the MOH, USAID might more productively offer technical assistance to the MOH to help it disburse anticipated higher levels of funding expected from budget support and HIPC.

Over time, USAID assistance has had a significant and positive impact on MOH policy. Some successes include development and promotion of IMCI, intermittent presumptive therapy for malaria, emergency obstetric care, and provision of a broad menu of contraceptives at decentralized public health facilities. During the current strategy, USAID provided assistance to strengthen local government involvement in decentralized health planning and finance. The project fostered widespread understanding of decentralization – health and administrative – and the new roles and responsibilities it implies, as well as much greater understanding of what "public health" means. Given the experience, however, the Consultant does not recommend a separate "decentralization" instrument but rather encourages USAID to incorporate attention to decentralization as a cross-cutting theme in any health services and health finance efforts in future support.

The Assessment recommends that USAID's future assistance to the health sector focus on developing/adapting technology packages, nurturing formulation of necessary policy reforms, and promoting development of protocols, norms, standards, training curricula, etc. to implement the innovations. The technical domains would continue to represent Senegal's health priorities as expressed in the PNDSS-II and PDIS-II, including child survival (to include malaria), maternal health/family planning, STI/HIV/AIDS, and health financing. Attention to tuberculosis should be integrated to the extent possible into a minimum package of care, and increased emphasis on community- and/or worksite-based directly observed treatment-short course (DOTS) should be pursued. Particularly in urban areas that comprise 45% of Senegal's population, because private practitioners are an increasingly important segment of the health referral system USAID should include private providers and supporters in all future health activities on an equal, strategic and deliberate basis as public providers in CS, MH/FP, STI/HIV/AIDS, and health financing.

In this problem-centered strategy, because USAID would not support routine service delivery it could gradually phase out of "USAID focus districts." This would theoretically reduce CA management costs and free up funds for higher-impact activities in the technical domains.

# USAID/SENEGAL HEALTH PROGRAM & STRATEGIC OPTIONS ASSESSMENT

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## GLOSSARY OF TERMS USED

<b>ADEMAS</b>	Agence pour le Développement du Marketing Social
<b>AIDS</b>	Acquired Immuno-Deficiency Syndrome
<b>ARPV</b>	Association des Relais Polyvalent
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretroviral drugs
<b>BASICS</b>	Basic Support for Institutionalizing Child Survival, a USAID-financed project administered by the Partnership for Child Health, Inc.
<b>BSS</b>	Behavior Surveillance Survey
<b>CAs</b>	Cooperating Agencies
<b>CEDPA</b>	Center for Development and Population Activities
<b>CFAF</b>	<i>Communauté Financière de l'Afrique (Franc)</i> : Local Currency of the Member States of the West African Monetary Union
<b>CI</b>	Counterpart International
<b>CMS</b>	Commercial Market Strategies
<b>CPTs</b>	Contraceptive Procurement Tables
<b>CRS</b>	Catholic Relief Services
<b>CS</b>	Child Survival
<b>CSO</b>	Civil Society Organization
<b>CSP</b>	Country Strategic Plan
<b>CYP</b>	Couple-Years of Protection
<b>DANSE</b>	Division de l'Alimentation, de la Nutrition et de la Survie de l'Enfant
<b>DAP</b>	Development Activity Proposal
<b>DFS</b>	Decentralized Financial System
<b>D/G</b>	Democracy and Governance
<b>DGL Felo</b>	Décentralisation, Gouvernance Locale, Progrès (USAID D/G SO project)
<b>DHS</b>	Demographic and Health Survey
<b>DISC</b>	Décentralisation et Initiatives de Santé Communautaire, a USAID-financed project administered by Development Associates, Inc., Abt Associates Inc., and the Umbrella Support Unit.
<b>DISE</b>	Division de l'Immunisation et de la Surveillance Epidémiologique
<b>DLS</b>	Division de la lutte contre le SIDA et les IST
<b>DSR</b>	Division de la Santé Reproductive
<b>FFP</b>	Food For Peace
<b>FHI</b>	Family Health International
<b>FP</b>	Family Planning
<b>FY</b>	Fiscal Year
<b>GDP</b>	Gross Domestic Product
<b>GOS</b>	Government of Senegal
<b>HIV</b>	Human Immunodeficiency Virus
<b>HMIS</b>	Health Management Information System

<b>IBRD</b>	International Bank for Reconstruction and Development
<b>IEC</b>	Information, Education and Communication
<b>IEE</b>	Initial Environment Examination
<b>IMF</b>	International Monetary Fund
<b>IRs</b>	Intermediate Results
<b>IUDs</b>	Intra-Uterine Devices
<b>KIR</b>	Key Intermediate Result
<b>LOA</b>	Life of Activity
<b>LPG</b>	Loan Portfolio Guarantee
<b>LGUs</b>	Local Government Units
<b>MAP</b>	Mauritania Anti-poverty Program
<b>MCH</b>	Maternal and Child Health
<b>MH</b>	Maternal Health
<b>MIS</b>	Management Information System
<b>MOH</b>	Ministry of Health
<b>MSH</b>	Management Sciences for Health
<b>MT</b>	Metric Ton
<b>NGO</b>	Non-Governmental Organization
<b>NRM</b>	Natural Resource Management
<b>OE</b>	Operating Expense
<b>P.L. 480</b>	Public Law 480, the Agriculture and Trade Development Act of 1954, as amended
<b>PMP</b>	Performance Monitoring Plan
<b>POPTECH</b>	Population Technical Assistance Project
<b>PREMAMA</b>	Prevention of Maternal Mortality
<b>PVO</b>	Private Voluntary Organization
<b>SDPs</b>	Service Delivery Points
<b>SERDHA</b>	Services d'Etudes et de Recherche pour le Développement Humain en Afrique
<b>SNEIPS</b>	Service National de l'Information et de l'Education pour la Santé
<b>SO</b>	Strategic Objective
<b>SPO</b>	Special Objective
<b>STI</b>	Sexually Transmitted Infection
<b>UNDP</b>	United Nations Development Program
<b>UNFPA</b>	United Nations Fund for Population
<b>UNICEF</b>	United Nations Children's Organization
<b>USAID</b>	United States Agency for International Development
<b>USDH</b>	U.S. Direct Hire
<b>USG</b>	United States Government
<b>WARP</b>	West Africa Regional Program

**WHO**      World Health Organization

# USAID/SENEGAL HEALTH PROGRAM & STRATEGIC OPTIONS ASSESSMENT

## 1. PURPOSE OF THE ASSESSMENT

USAID/Senegal is currently implementing its FY 1998-2006 Country Strategic Plan, which includes strategic objectives (SOs) in private sector development, democracy and governance, health, and education, and a Casamance special objective to promote peace and economic development in that region. Activities in agriculture and natural resources management are also undertaken through the private sector and democracy SOs.

The USAID/Senegal SO for health is *increased use of decentralized health services in targeted areas*. The USAID health portfolio supports the goals and objectives of the Government of Senegal's (GOS) 1998 – 2007 National Plan for Health and Social Development, (PNDSS) and has contributed to impressive results in the technical domains of child survival, maternal health, family planning, HIV/AIDS and sexually transmitted infections (STIs), malaria and tuberculosis (TB), decentralization, health financing, and gender.

The current USAID/Senegal strategy ends in September 2006. In anticipation of continued involvement in the health sector, USAID contracted CRI Consult, Inc. to prepare two analytic pieces to assist in its planning. CRI's first product is this **Health Program & Strategic Options Assessment**, which is intended to help USAID/Senegal determine whether its efforts in the health sector have been productive and successful, and to help guide the development of new directions in the next phase of USAID assistance to Senegal. As instructed in the contract, CRI used a methodology that combined secondary documents review and analysis with key informant (individual and group) interviews in Dakar and limited field sites in Kaolack and Thies. The full CRI Scope of Work is provided as Annex A. A complete List of Persons Contacted and Schedule is presented in Annex B and a listing of Selected Documents Reviewed as Annex C. Of particular note is the USAID/Senegal Health Portfolio Assessment of June-September 2002 by Gary Merritt and Col. Oumar Ndiaye; it is the only external review of activities during the 2000 – 2004 period. It is hereinafter referred to as the "Mid-Term Assessment."

This paper begins with a **Background and Context** overview (section 2) that includes selected health statistics; a summary of GOS health development and related plans; and a description of the USAID/Senegal 1998-2006 strategy that contributes to achievement of the GOS plans. This background section is followed by a more detailed presentation of the **Current USAID/Senegal Health Portfolio** (section 3) and its achievements and continuing challenges. Section 4 then examines specific **Key Issues** related to the strategy and portfolio that have been identified by USAID and its partners (ref. Annex A). The paper concludes with a section on **Lessons Learned** (section 5) and **Strategic Options for Consideration** (section 6).

## 2. BACKGROUND AND CONTEXT

### 2.1 Summary Context and Health Situation<sup>1</sup>

Senegal has progressed significantly in the past decade both politically and economically. This is due primarily to its strong commitment to ruling justly, investing in people, and promoting economic freedom. The country's longstanding democratic tradition and stability, however, have not translated into a better living standard for many of its 10 million people. The country

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<sup>1</sup> The first two paragraphs of this section are taken almost verbatim from USAID/Senegal's 2005 Annual Report, A. Program Performance Summary.

faces severe challenges: nationwide, 50% of young men have no jobs, 70% of women over 15 years are illiterate, and 70% of the countryside has no electricity. Population growth has averaged 2.6% while economic growth has averaged only 5% per year -- not enough to provide jobs for a rapidly growing, young population. Social indicators are improving due to substantial government and donor investment in education, health, and other social services. As a result of agreements reached under the Highly Indebted Poor Country (HIPC) program, the GOS is now devoting 40% of its budget to education (up from 33% in 2003) and 10% to health. While economic growth has picked up (estimated at 6.5% in 2004), it has not yet had sufficient impact on alleviating overall poverty. The percentage of persons living in poverty in 2001 was 57.1%. The GOS is committed to reducing the incidence of poverty to 50% by 2015. Poverty reduction on this scale, however, will require achieving annual growth rates of at least 8%.

Senegal urgently needs growth, jobs, and the capacity to produce and manufacture goods rather than just trade them. In the social sectors, Senegal has increased the gross access ratio to the first grade of primary school from 72.36% in 1996 to 85.1% in 2003. Vaccination rates have increased to 70% after a precipitous drop in the late 1990s due to reduced donor funding. Good leadership, early policy dialogue, and social mobilization have helped Senegal contain the spread of HIV/AIDS, with prevalence currently at 1.4% of the population. However, the Mission is concerned about the high estimated prevalence rate among registered commercial sex workers (20.9%) and the rapid increase among young pregnant women aged 15 to 24 (0.74% in 2002, 1.26% in 2003).

For reference, Table 1 below provides national level data on Senegal's health status from the 1997 Demographic and Health Survey (DHS) and the 1999 Enquête Sénégalaise sur les Indicateurs de Santé (ESIS)

**Table 1: Selected Health Indicators for Senegal, 1997-1998**

Indicator	Date	Source
Infant Mortality per 1000 live births	64	ESIS
Neonatal Mortality per 1000 live births	31	ESIS
Child Mortality per 1000 live births	143	ESIS
Maternal deaths per 100,000 live births	510	DHS
Total Fertility Rate	5.7%	DHS
Contraceptive Prevalence Rate – modern methods	7.1%	ESIS
Proportion of pregnancies receiving at least one prenatal visit	82%	ESIS
Assisted deliveries	48%	ESIS
Proportion of children fully vaccinated by age one as evidenced by vaccination cards	37.8%	DHS
HIV prevalence	1.4%	GOS
HIV prevalence among commercial sex workers	15-35%	various
Proportion of persons in high-risk groups reporting condom use with non regular partner during last sexual act	88%	ESIS

The Table 1 data mask the vast difference in the health status of urban and rural populations in Senegal. Evidence of this phenomenon is clear in the 1997 Senegalese DHS data. For example, child mortality in the rural areas was 79 per 100,000 versus only 50 in urban areas, and contraceptive prevalence (modern methods) was only 2.1% in rural areas, as opposed to 19.3% in urban areas.

The rural – urban imbalance is cross-cut by a sharp division in income levels:

**Senegal is two nations.** One is approaching middle-income levels. It has access to middle class levels of education, public service, health care, housing, financial services, social protection, and urban amenities. The other – larger – nation exists near or below the poverty line. It is rural or lives in urban slums and is ill fed, ill clothed, ill housed, insecure and uneducated.

**Income distribution is highly unequal between literate and illiterate, urban and rural, Dakar and the rest of Senegal.** ... In 2001, Dakar had 23 percent of the population and 38 percent of private consumption; rural areas had 59 percent of the population and 42 percent of private consumption. Citizens of Dakar had a daily expenditure of 7,285 CFAF which those of other cities had 5,331 CFAF and rural people spent only 3,779 CFAF.<sup>2</sup>

The World Bank's December 2004 Senegal Public Expenditure Review documents that Senegal's health indicators register a strong degree of inequality across the different regions of the country<sup>3</sup>:

- Inequalities in the under-five mortality rates in Senegal are among the worst in the West Africa region.
- In terms of child malnutrition, underweight prevalence among the poorest 20% stands at twice the level of the richest 20% and stunting prevalence among the poorest 20% has deteriorated to three times the level of the richest 20%.
- While total fertility rates have declined to 3.9 among urban women, they still stand at a relatively high level of 6.1 in rural areas.
- In Dakar the proportion of households with piped water is above 70%, whereas in Thies, this proportion falls to 27% and in Kolda – the poorest region in Senegal – it is only 3%.
- While 80% of the urban population lives within 30 minutes of a health facility, in the rural areas only 42% of the population live within 30 minutes from health facilities, and 43% live beyond 1 hour from health facilities.
- There are large disparities within regions. In the two poorest regions of Kaolack and Kolda, the geographical accessibility of health services is twice as low as Dakar.

As described below, the GOS and its donor partners, including USAID, are working to redress these imbalances.

## **2.2 Summary of Government of Senegal Policies and Strategies 1999-present**

To address the health status and inequalities summarized above, in 1997 the GOS Ministry of Health (MOH) developed a national health program (the National Plan for Health and Social Development, or PNDSS) for the period 1998 to 2007 which has three specific expected results: i) reduced infant, child, and maternal mortality; ii) a decreased fertility rate; and iii) decreased morbidity and related social problems. The PNDSS lists eleven strategic orientations that will help it achieve these objectives. These are:

- a) improvements and reforms in the regulatory and legal environment;
- b) increased access to services
- c) increased quality of care

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<sup>2</sup> Memorandum of the President of the International Development Association to the Executive Directors on a Country Assistance Strategy for the Republic of Senegal, pp. 1 -2.

<sup>3</sup> The bullets are adapted from the World Bank Senegal Public Expenditure Review, pp. 44-45.

- d) development of human resources
- e) increased performance of reproductive health programs
- f) strengthened endemic disease monitoring and epidemiological surveillance
- g) promotion of hygiene and sanitation measures for individual and community protection
- h) assistance to the private sector and to traditional medicine
- i) development of operations research
- j) improved well being for destitute families and other vulnerable groups
- k) institutional strengthening at the central, regional, and district levels

The first five years of the PNDSS (1998 – 2002) were further specified and budgeted in the Integrated Health Development Program (PDIS). The PDIS consolidated the development plans of the regions, districts, and those of the central services. The GOS has reviewed the PDIS and is in the process of finalizing a PDIS-II to implement the second phase of the PNDSS.

The Consultant was unable to review the PDIS-II but was informed that all eleven strategic orientations remain valid, and that an additional strategic orientation related to poverty alleviation has been added. USAID and other donors are continuing to work with the GOS to assure that operational plans respond to these needs.

## 2.3 Summary of USAID/Senegal 1998-2006 Strategy

### 2.3.1 Overall Mission Strategy 1998-2006

USAID/Senegal's overall goal for the 1998-2006 period is *Sustainable Economic Development through Broadened Social, Political, and Economic Empowerment*. As of FY 2005, there are five operational strategic objectives (SOs) in the Country Strategic Plan (CSP):

- **Private Sector Strategic Objective (PRSO) or SO1:** *Sustainable Increases in Private Sector Income-Generating Activities in Selected Sectors.*
- **Decentralization & Governance SO or D/GSO2:** *More Effective, Democratic and Accountable Management of Services and Resources in Targeted Areas.*
- **Health SO or SO3:** *Increased Use of Decentralized Health Services in Targeted Areas (note: The original Health SO was much longer. USAID/Senegal notified USAID/Washington of its simplification of the statement in its March 2002 Annual Report.)*
- **Casamance SO9:** *Improved Enabling Conditions for Peace via Economic, Social and Political Development.*
- **Education SO10:** *Increased Access to and Improved Quality of Middle School Basic Education, especially for Girls*

USAID/Senegal developed the original strategy (SOs 1, 2, and 3) through a widely publicized “demand-driven approach” involving an extensive consultative process with literally thousands of Senegalese. To implement the strategy, USAID intended to conduct a nationwide information campaign to explain its goals, describe USAID's procedures, and solicit proposals from Senegalese individuals, government, and non-governmental entities. USAID intended that a contractor would help to assure that proposals were completed and forwarded to USAID/Senegal for review and approval against established criteria. (*ref. CSP 1998-2006*).

The CSP was approved in March 1998 and Strategic Objective Agreements (SOAGs) for each SO were signed in August-September of 1998. Between September 1998 and mid-1999, the

Mission found that its initial idea of the nationwide proposal process would be difficult to execute given US Government contracting and financing parameters. In 1999 the Mission issued a number of solicitations for more standard contracts/cooperative agreements to help implement the program, and activities in the three major SOs were underway by mid-to-late 2000. This shift in implementation modes coincided with a shift in USAID Directors, a change in leadership of the USAID Health SO Team, and personnel turnover in the GOS as part of the run-up to the 2000 Senegalese elections. Much of the impetus for the “demand-driven” approach – as characterized by the nationwide proposal process -- was dissipated.

As of this 2005 Assessment, some USAID staff still express dismay that the “demand-driven” approach was dropped. Based on some key informant interviews, the Consultant concluded that there are certainly numerous health-related activities – notably water supply and some community-based initiatives, and perhaps some studies or operations research activities – that might have come to USAID’s attention and been financed had a broader publicity campaign been undertaken. On the other hand, there are probably an equal number of activities that were undertaken with communities and community-based groups that might not have been financed had USAID-financed contractor/cooperating agency (CA) staff not approached the community directly and provided orientation and training (*encadrement*) on public health. The Consultant’s conclusion is that program implementation in fact included explicit mechanisms to solicit and respond to the expressed needs of communities and local governments within the parameters of USAID’s funding earmarks and program regulations, and that much of the intent of the “demand-driven” CSP was met.<sup>4</sup>

### **2.3.2 The Health Strategy 1998-2006**

The 1998-2006 CSP includes elaboration of a full results framework for the Health SO3, *Increased Use of Decentralized Health Services in Targeted Areas*, including three Key Intermediate Results (KIRs) and ten related subsidiary IRs:

#### **KIR-3.1 Improved access to quality child survival, maternal health, family planning, and sexually transmitted diseases/AIDS services**

Activities contributing to KIR-3.1 were expected to increase access to maternal health (MH), family planning (FP), selected child survival (CS), and STI/AIDS prevention services. There were four IRs:

- IR 3.1.1 Functionality of existing public health SDPs improved.
- IR 3.1.2 Network of private sector SDPs expanded.
- IR 3.1.3 Coordination between public and private sector services improved.
- IR 3.1.4 Program management and technical monitoring of public and private sector services improved.

#### **KIR 3.2 Increased demand for quality child survival, maternal health, family planning, and sexually transmitted diseases/AIDS services.**

Activities contributing to KIR-3.2 were expected to improve clients' knowledge of the location of service delivery points (SDPs), the types of services offered, and the advantages and disadvantages of the various services. Activities to achieve this KIR were expected to promote community actions and solicit support for reproductive health services among the social leadership and community networks. There were 3 IRs:

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<sup>4</sup> Note, however, the Author also assisted the Mission in development of the 1999 solicitations.

- IR 3.2.1 Increased knowledge of the benefits of CS, MH, FP, and STI/AIDS services.
- IR 3.2.2 Increased participation of opinion leaders (religious, political and civil) in social mobilization.
- IR 3.2.3 Private sector information-education-communications (IEC) activities expanded.

### **KIR 3.3 Increased financing of health services from internal sources.**

Activities contributing to KIR-3.3 sought to increase the capacity of local communities and government units to provide basic reproductive health services on a sustainable basis using locally-generated resources. The KIR was to be achieved by strengthening the management capacity and transparency of local government units; by involving local populations, grassroots groups and NGOs in planning and evaluating services offered by their local governments; by lobbying for additional resources from the central level; and by ensuring that national health policies favor sustained local financing of services. There were 3 IRs:

- IR 3.3.1 Total local and central government resources allocated to health increased in real terms.
- IR 3.3.2 Total non-government resources allocated to health increased;
- IR 3.3.3 A monitoring system for the legal and regulatory framework for health made functional.

To achieve these results, the SO3 Health Team planned to work in four technical domains and at three levels of focus:

The technical domains represent Senegal's health priorities as expressed in the PNDSS and PDIS, and are CS, MH/FP, STI/HIV/AIDS, and decentralized health financing (HF). Implementing partners working in the first three technical domains – CS, MH/FP, and STI/AIDS – were to contribute primarily to achievement of KIRs 3.1 (access) and 3.2 (demand) above. Implementing partners working in health financing were to contribute primarily to the achievement of KIR 3.3. However, the SO3 team explicated designed mechanisms for collaboration and joint efforts between and among the partners to assure an integrated, cost-effective approach to improving use of sustainable reproductive health services overall.

The levels of focus recognized the new challenges of decentralization; they were: i) local level health services and systems support in SO3's core health districts, including development, implementation, and monitoring and evaluation of local health action plans that integrate all technical domains; ii) nationwide service delivery, including training and supervision in application of service delivery norms and protocols -- medical, outreach, information-education-communications (IEC)/behavior change communications (BCC), logistics -- throughout the country in each technical domain; and iii) national systems support, including policy dialogue, research, monitoring and evaluation, and information dissemination and communication in each technical domain.

The intended relationships between the two dimensions and among the domains and levels are shown in Figure 1 on the next page. (The Figure is reproduced from the Health Team's common background to the bilateral RFP and RFA in 2000). The sections that follow the Figure summarize how implementation evolved and highlight some of the results to date.

**Figure 1: PLANNED Illustrative SO3 Interventions by Level of Focus and by Technical Domain (November 1999)**

LEVELS DOMAINS	LOCAL LEVEL SERVICES & SYSTEMS in 29 HPN core Health Districts	NATIONWIDE SERVICES DELIVERY	NATIONAL LEVEL SYSTEMS SUPPORT
CHILD SURVIVAL (KIRS 3.1 & 3.2)	<ul style="list-style-type: none"> <li>• "Healthy Child Menu of Services" developed, costed, and promoted as part of local-level health care package;</li> <li>• Innovative programs to improve quality of CS services at health huts and health posts developed and implemented</li> <li>• Local grassroots organizations (e.g. Health Committees, Mother's Clubs) participation in CS outreach &amp; services strengthened</li> </ul>	<ul style="list-style-type: none"> <li>• Basic care: immunization, nutrition monitoring, Vitamin A, exclusive breast feeding, IMCI, malaria prevention &amp; treatment, ARI, BCC, IEC strengthened (TA, training, supervision, material, equipment)</li> <li>• National Immunization Days &amp; other special events supported</li> <li>• Bamako Initiative for essential drugs supply &amp; cost recovery supported.</li> </ul>	<ul style="list-style-type: none"> <li>• Policy dialogue: national dialogue on key CS issues supported</li> <li>• Monitoring &amp; Evaluation: MICS and other useful monitoring tools supported</li> <li>• Research: operations research on key CS topics, as necessary</li> <li>• Information Dissemination to encourage use of data for decision making.</li> </ul>
MATERNAL HEALTH/ FAMILY PLANNING (KIRS 3.1 & 3.2)	<ul style="list-style-type: none"> <li>• "Maternal Health Menu of Services" developed, costed, and promoted as part of local-level health care package;</li> <li>• "Family Planning Menu of Services" costed and promoted as part of local-level health care package;</li> <li>• Innovative programs to improve quality of MH/FP care at health huts and health posts developed and implemented</li> <li>• Local grassroots organizations (e.g. Health Committees, Mother's Clubs, Youth Clubs) participation in MH and FP outreach &amp; services strengthened</li> </ul>	<ul style="list-style-type: none"> <li>• Basic care: emphasis on quality of care, immunization, IEC strengthening (TA, training, supervision, materials, equipment)</li> <li>• Integration of contraceptive commodities into essential drugs logistics &amp; price structures continued; social marketing of condoms and hormonal expanded</li> <li>• National communications strategy developed, and implemented</li> <li>• PVOs/NGOs &amp; private commercial providers roles in FP increased</li> </ul>	<ul style="list-style-type: none"> <li>• Policy dialogue: national dialogue on key MH/FP issues supported</li> <li>• Monitoring &amp; Evaluation: National Contraceptive Procurement Tables (CPTs) maintained; key MH and FP indicators followed;</li> <li>• Research: operations research on key MH/FP topics, e.g. as women's health (fistulas) and treatment seeking behaviors</li> <li>• Information Dissemination to encourage use of data for decision making.</li> </ul>
STI/AIDS (KIRS 3.1 & 3.2)	<ul style="list-style-type: none"> <li>• "STI/AIDS Menu of Services" developed, costed, and promoted as part of local-level health care package;</li> <li>• Innovative STI/AIDS prevention interventions for women, youth, migrants developed and implemented</li> <li>• Innovative programs to assist AIDS orphans and people/ families living with HIV developed and implemented</li> <li>• Innovative interventions to empower commercial sex works to protect themselves and/or change professions developed and implemented</li> <li>• Local grassroots organizations (e.g. Health Committees, Mother's Clubs, Youth Clubs) participation in STI/AIDS outreach &amp; services strengthened</li> </ul>	<ul style="list-style-type: none"> <li>• Basic Care: STI syndromic treatment strengthened (TA, training, supervision, material, equipment):</li> <li>• Targeted, innovative interventions for geographic, demographic high-risk cohorts developed &amp; implemented</li> <li>• Social organizations &amp; private companies mobilized for HIV/AIDS prevention &amp; care</li> <li>• Participation of people living with HIV increased in national program development and delivery</li> <li>• National Communications strategies (e.g. mass media, special events) developed and implemented</li> </ul>	<ul style="list-style-type: none"> <li>• Policy dialogue: national &amp; international STI/AIDS policy dialogue continued and strengthened</li> <li>• Monitoring &amp; Evaluation: "Second Generation" sentinel surveillance strategy refined, implemented</li> <li>• Research: Operations research in community-based services strategies; IEC and STI management; etc.</li> <li>• Information Dissemination to encourage use of data for decision making.</li> </ul>
HEALTH FINANCING (KIR 3.3)	<ul style="list-style-type: none"> <li>• Matching Grant program to stimulate local resources generation implemented for 2 year period/district;</li> <li>• CS, MH, FP, STI/AIDS services menus collaboratively developed, costed, and promoted as part of cost-recovery scheme by local managing entities;</li> <li>• Local resource mobilization (e.g. money, labor, in-kind resources) for health care increased.</li> <li>• Local capacities to plan, implement, monitor RH services improved in up to 29 health districts</li> <li>• Local advocacy/leverage for RH funding increased</li> </ul>	Not foreseen	<ul style="list-style-type: none"> <li>• Policy dialogue: national decentralized financial systems advocacy strengthened; legal framework for decentralized entities promoted</li> <li>• Monitoring &amp; Evaluation: national budgetary allocations to decentralized structures monitored &amp; analyzed</li> <li>• Information Dissemination to encourage use of data for decision making.</li> </ul>

### 3. CURRENT USAID/SENEGAL HEALTH PORTFOLIO

#### 3.1 Summary of Current Health Portfolio

As stated above, during 1999-2000 the Mission undertook solicitations for technical assistance and otherwise accessed SO3 Health implementing partners through routine USAID processes. Although the Health Team initially thought to obtain management efficiencies by minimizing the number of implementing partners, by March 2005 there were 15 cooperating agencies (CAs) working in the four original technical domains plus two new ones – malaria and tuberculosis -- and at two broad levels of focus. These CAs collaborate with numerous GOS, NGO, private commercial, local government, and community actors throughout Senegal. Figure 2 on the next page provides a summary listing of the partners and their key technical domains and levels of focus. (Ref. Glossary of Terms Used at pp. iv-v for explanation of acronyms).

Table 2 below shows the USAID funding allocation for FY 2004 by technical domain and at the two levels of focus. The proportions can be considered indicative of FY 2003 – 2005 levels.

**Table 2: Allocation of FY 2004 Funding by Technical Domain and Level of Focus<sup>5</sup>**

		<b>Local Services &amp; Systems – 46.2%</b>	<b>National Services &amp; Systems – 39.9%</b>
<b>PROGRAM</b>	<b>85.5%</b>		
CS – KIRs 3.1 & 3.2	9.6%	5.9%	3.8%
MH/FP – KIRS 3.1 & 3.2	22.6%	9.9%	12.7%
HIVAIDS – KIRS 3.1 & 3.2	23.4%	7.9%	15.5%
Health Finance – KIR 3.3	19.2%	17.7%	1.6%
Other Technical - TB, Malaria – KIRs 3.1 & 3.2	10.6%	4.9%	5.7%
<b>FY 2004 UNALLOCATED</b>	<b>7.3%</b>		
<b>USAID MANAGEMENT</b>	<b>7.2%</b>		

With reference to the original schematic at Figure 1 on the previous page, it became apparent early in the strategy that the difference between “nationwide services” and “national systems” was not operational, and analysis at this level is not possible. The addition of activities in the technical domains of tuberculosis and malaria were dictated by both need and availability of funding earmarks.

Of interest is the fact in the Illustrative CSP Budget for the Health SO3 (CSP, p. 77), an annual budget of about \$8.6 million was anticipated. In fact, the overall totals for FY 2003-2005 have averaged almost \$15 million, with most of the increase attributable to HIV/AIDS funding.

Of particular note is the evolution of “local services and systems.” The original SO3 design assumed work in 29 Health Districts across the six regions of Louga (5 health districts), Thies (8 health districts), Kaolack (4 health districts), Ziguinchor (3 health districts), Fatick (6 health districts), and Dakar (3 rural health districts). Given availability of funds, however, USAID dropped the 3 rural districts of Dakar and 5 of the 6 in Fatick. As of the 2002 Mid-Term Assessment partners were working in 15 health districts in the five regions, and expanded to the total of 21 in FY 2004 based on the findings of that Assessment.

<sup>5</sup> Table constructed by Consultant based on FY 2004 OYB allocations provided by USAID, with reference to assumptions of allocations as shown in Figure 2 overleaf.

<b>Figure 2: Summary SO3 Partners by Technical Domain, KIR, and Levels of Focus</b>		
<b>PROGRAM</b>	<b>LOCAL SERVICES &amp; SYSTEMS</b>	<b>NATIONAL SERVICES &amp; SYSTEMS</b>
CS – KIRs 3.1 & 3.2	<ul style="list-style-type: none"> <li>• BASICS (75% resources) delivery of “Healthy Child” Menu in 21 focus districts (ref. Figure 1 for illustrative activities)</li> </ul>	<ul style="list-style-type: none"> <li>• BASICS (25% resources), for IMCI, malaria, ARI, neonatal protocols, norms, standards with DANSE, DISE, DSR, and SNEIPS.</li> <li>• WHO-Polio funding for NIDS with DISE</li> <li>• NETMARK for distribution and sales of insecticide treated bednets for children under 5</li> </ul>
MH/FP – KIRS 3.1 & 3.2	<ul style="list-style-type: none"> <li>• PREMAMA (75% resources) delivery of “Maternal Health” and “Family Planning” and “Men As Partners” Menu, as well as formative supervision for PMTCT and VCT, in 21 focus districts (ref. Figure 1 for illustrative activities)</li> </ul>	<ul style="list-style-type: none"> <li>• PREMAMA (25% resources) for post-abortion care (PAC), contraceptive tables &amp; logistics, reproductive health protocols, norms, standards, STI and PMTCT formative supervision, with DSR and DANSE.</li> <li>• NETMARK for distribution and sales of insecticide treated bednets for pregnant women</li> <li>• ADEMAs for contraceptive social marketing: condoms, oral contraceptives</li> <li>• CEDPA for capacity building for women’s and youth CBOs: advocacy, management, networking, e.g. income-generation, etc.</li> <li>• USAID Central Procurement for contraceptives for public distribution (via PREMAMA) and social marketing (via ADEMAs)</li> </ul>
HIVAIDS – KIRS 3.1 & 3.2	<ul style="list-style-type: none"> <li>• FHI (50% resources) delivery of prevention services targeting high-risk populations</li> </ul>	<ul style="list-style-type: none"> <li>• FHI (50% resources) support for national level sentinel surveillance system (with Le Dantec), Behavior Surveillance Survey in 2002, and protocols, norms, standards for STI, VCT, PMTCT, ART, with CNLS and DLS.</li> <li>• ADEMAs for condom social marketing, IEC</li> <li>• CEDPA for capacity building of women’s and youth CBOs for HIV/AIDS prevention</li> </ul>
Health Financing – KIR 3.3	<ul style="list-style-type: none"> <li>• DISC (90%resources) local health planning &amp; budgeting &amp; Matching Grant program in 21 focus districts</li> <li>• PHR-Plus (90% resources) <i>mutuelles</i> in focus districts</li> </ul>	<ul style="list-style-type: none"> <li>• DISC (10% resources) advocacy, norms, systems for decentralized health finance</li> <li>• PHR-Plus (10% resources) strengthening of <i>mutuelles</i> with socio-political organizations UNACOIS in Dakar and Kaolack and <i>Mouride Matlaboul Fawzaini</i> in Touba, and national advocacy and TA to MOH</li> </ul>
Other Technical – KIRS 3.1 & 3.2	<ul style="list-style-type: none"> <li>• Africare in Ziguinchor, Plan at sites in Louga, Thies, CCF in Thies provision community-based malaria and TB prevention and control programs</li> </ul>	<ul style="list-style-type: none"> <li>• International Union for Tuberculosis Control provision of formative supervision and support to National TB Program (PNT)</li> <li>• WHO grant to support National Malaria Program (PNLP) personnel, supervision, pilot activities.</li> <li>• US PDQI assistance to national pharmaceutical quality assurance, norms, standards</li> <li>• RPM-Plus assistance to national essential drug supply and logistics programs</li> </ul>

The “local services and systems” shown in Figure 2 are not limited to the 21 health districts. The lead CA for HIV/AIDS, Family Health International (FHI) works at selected sites throughout Senegal targeting high risk groups, e.g. sex workers, transporters, fishermen, men who have sex with men (MSM), and persons living with HIV and AIDS (PLWHA). Because poverty is a key driver of the HIV/AIDS epidemic, FHI also undertakes capacity building for Senegalese NGOs who are addressing poverty through community-based interventions for the general populations.

One of the three CAs working on TB and Malaria – Africare– also undertakes a centrally funded Child Survival Grant outside of the SO3 focus districts (Tambacounda). Finally, although the resource allocation is not including in Table 2, two PVO partners are launching SO3-related P.L. 480 Title II food aid programs in FY 2004: Counterpart International will address maternal and child health and nutrition and HIV/AIDS in Podor Health District in Matam Region, and Catholic Relief Services hopes to address care and support of persons living with HIV and AIDS in Dakar. The intensive coverage afforded by these partners brings USAID’s “local services & systems” coverage up to about 60% of Senegal’s population.

As shown in Figure 2, the CAs work with the GOS, NGO, and private commercial health care providers at the national, regional, health district, and local levels. USAID CAs work with MOH as well as locally elected and appointed officials and NGO and community leaders at each level. The relationships are described in detail in the 2002 Mid-Term Assessment (Col. Ndiaye) and remain strong and productive to date. Section 4 below provides some specific comments and recommendations with regard to strengthening relationships further.

The 2002 Mid-Term Assessment (Merritt) reported that GOS officials interviewed “... expressed dismay that no one from the GOS was involved in drawing up the terms of reference for the bidding applications for CA selections more than two years ago, that none were involved in the selection of the CAs nor in the negotiation over final submission details nor directly in selection of key personnel.” (Portfolio Assessment, p. 9). This 2005 assessment did not encounter the same concerns and found generally strong relationships across the portfolio at all levels.

### **3.2 Significant Achievements 2000-2004**

Table 3 on the next page provides a summary of the SO3 baseline and achievements to date for the indicators that it tracks. There are several SO-level indicators that cannot be reported until the 2005 DHS data are available, estimated for June 2005. The data that are available show, however, that the SO3 Health program has generally achieved all that it set out to do.

To complement the DHS and ESIS data from 1997-1998, in 2003, USAID conducted a household and facility survey in 15 USAID-assisted health districts. USAID is contemplating undertaking some district-specific analyses of data subsets from the forthcoming 2005 DHS data to isolate the impact of USAID assistance. The Consultant strongly encourages this effort, to obtain empirical evidence of success.

**Table 3: USAID/Senegal SO3 Performance Management Plan Data, Baseline and 2004**

Dimension	Indicator	Baseline Source	Baseline Data	2004 Actual
SO	Couple Years of Protection	MSH, 2004	184,606	225,524
SO	Number of persons using the services of USAID-sponsored VCT centers (Oct. thru Sept.)	HIV/AIDS Services 2001	1,736	6,910
KIR 1	Number of USAID-sponsored Voluntary Counseling and Testing (VCT) centers	FHI, 2001	1	9
KIR 1	% of SDPs, within USAID supported areas, applying IMCI	BASICS, 2001	10.3	72
KIR 1	% of SDPs that implement intermittent preventive treatment for prevention of malaria in pregnancy	MSH, 2004	TBD	100
KIR 1	% of health district depots that do not experience any stock-out of contraceptives	MSH, 2000	30	56
KIR 2	Number of PROTEC-brand condom sales points operating on September 30	ADEMAS 1999	1,683	4,134
KIR 3	Amount transferred by local government units (within USAID targeted areas) into the Matching Funds Account as of December 31 <sup>st</sup>	1999	\$50,100	TBD for 2004 \$571,935 in 03
KIR 3	Number of beneficiaries of health mutual organizations	PHR	15,781	44,922

The quantitative data in Table 3 mask some important more qualitative achievements. For KIR 1, *Improved access to quality child survival, maternal health, family planning, and sexually transmitted diseases/AIDS services*, USAID partners have helped upgrade equipment and infrastructure at numerous health centers and health posts throughout the 21 focus districts. Through community, private sector, and public outlets, USAID partners sold more than 318,500 insecticide-treated bed nets (ITNs). They have additionally collaborated with MOH and regional and district colleagues to provide training and formative supervision integrate numerous service strategies into MOH norms and expand access to these new strategies to many SDPs in USAID focus districts. Successes in IMCI and intermittent presumptive therapy are reported in Table 3. Other new strategies in the process of integration include:

- Community-based treatment of pneumonia.
- Community-based presumptive treatment of malaria.
- A new neonatal care package.
- A new post-partum hemorrhage package.
- Prevention of mother-to-child transmission of HIV, at all health centers.
- VCT at all health centers.
- Emergency obstetric care at health centers with operative capability.
- Post-abortion care at hospitals and health centers with operative capability.

USAID and its partners will continue to collaborate with MOH and civil society partners as these strategies are developed and will help assure scale-up when appropriate.

For KIR 2, *Increased demand for quality child survival, maternal health, family planning, and sexually transmitted diseases/AIDS services*, in addition to the expansion of sales outlets for contraceptives shown in Table 3, USAID and its partners have collaborated to increase IEC/BCC at community and mass population levels. One of the more innovative efforts is fostering of formal contractual relationships between *Associations des Relais Polyvalents* (ARPV) and local administrations in 123 Rural Communities. The ARPVs in each area regroup previous project- or topic-specific outreach workers for BASICS, PREMAMA, and other health activities into one well-trained association. The USAID projects DISC and PREMAMA facilitated development of and paid for formal contracts between the Rural Communities and the new associations. The ARPVs make quarterly workplans with the Rural Communities, district health offices, and USAID and other external funding agencies, to engage in various community outreach activities – discussions, fairs, etc. Although the effort is quite new, facility-level reporting indicates that there is an increase in use of facilities, including antenatal visits and sleeping under ITNs, that bodes well for health outcomes. The ARPVs are relatively affordable – about US\$3,500/district/year – so USAID hopes to interest other donors and/or funding agents in their support.

Both access and demand results have been stimulated by USAID's activities in support of KIR 3, *Increased financing of health services from internal sources*. To quote the FY 2005 Annual Report:

In support of national decentralization efforts, USAID has developed a model approach for helping locally-elected officials and civil society to develop annual health plans supported by local taxes and USAID matching funds. These USAID matching funds are gradually phased out as communities achieve sustainable health financing. Participatory planning and financing support to local collectivities was extended from 15 health districts in 2003 to 21 (out of 55 health districts nationwide) in 2004. ... To strengthen the oversight of community health committees, management committees were initiated in 46 local government units, and regional bodies are supporting local activities in health planning and financing.

Overall, USAID's widespread promotion of the concept of *public health* to local elected and appointed officials, community-based organizations, religious leaders, and other non-medical personnel has greatly strengthened potential for sustainability of efforts over time. Key challenges encountered in implementation of the strategy are discussed in section 4. below.

#### **4. Key Issues**

The questions presented in italics under each section below are from the CRI statement of work found at Annex A, and cover most of the challenges and issues encountered during implementation of the strategy.

##### **4.1 Government of Senegal and Ministry of Health**

*Why has there been less GOS/MOH involvement than expected in the process USAID/Senegal uses to implement health programs? How is USAID/Senegal's support of the GOS/MOH perceived? Do we need a more harmonized and formalized approach?*

**There has been significant GOS/MOH involvement in the implementation process at the national, regional, and district levels, particularly in focus regions.** Although there have

been normal ups-and-downs in relationships over the five years of the strategy, at the present time there are USAID-financed personnel sitting in offices at the national MOH (DSR, DANSE, DNA), National AIDS Committee (CNLS), National Tuberculosis Program (PNT), and National Malaria Program (PNLP) and functioning as full-time staff and/or advisors. There is day-to-day communication between USAID-financing implementing partners and MOH personnel. There are frequent and productive meetings between the MOH and USAID staff. There is an annual Joint Review process chaired by the Ministry of Finance.

The Consultant pursued this question of “less than expected” involvement at the national, regional, and district levels. In terms of perceived lack of involvement, regional personnel in Kaolack expressed concern that they had not received as much training and other capacity building attention as had Health District personnel in the region. This concern had been expressed by Regional personnel during the 2002 Mid-Term Assessment (Col. Ndiaye) as well, and bears noting for future consideration. Most District personnel were satisfied with their level of involvement, although one District Medical Officer expressed dismay over low levels of per diem and vehicles. In contrast, the Regional Director in Kaolack and the Director of Health (national) expressed great satisfaction with USAID’s 30 year partnership in provision of health services in Kaolack region, and the strong understanding of public health that the partnership has engendered. **On balance, the majority of informants stated that there was good two-way communication and involvement.**

*Should we consider institutional support: Set aside money for public sector operations such as logistics and transport? Should we follow the lead of other donors and consider non-project assistance?*

As reported in USAID/Senegal’s *FY 2005 Annual Report Cover Memo*:

The MCA Jumpstart exercise, conducted in collaboration with the Prime Minister’s Office, succeeded in raising awareness of the need for greater political leadership to raise unacceptably low rates of donor resource absorption (on average, just 30% of available donor resources are spent in a given year). ... The exercise also assessed the effect of donor management practices on aid utilization rates ... USAID/Dakar ... delivers some of the highest disbursement rates seen in Senegal (94% in 2004 vs. 12% to 20% for some of the largest donors). The Minister of Finance now routinely challenges others to match USAID’s effectiveness in overcoming local absorptive capacity constraints.

The World Bank found that:<sup>6</sup>

17. Public spending depends too much on aid. Net foreign transfers averaged ... 18 percent of government spending (3.2 percent of GDP) from 1997 through 2001. ... Public investment ... from foreign public sources was 54 percent [in 1997 – 2001].

18. Reliance on aid tends to centralize budget preparation – because the central government nearly monopolizes contact with donors – and to hinder budget execution, because of the diversity and complexity of aid procedures. The heavy tradition of aid dependence has diverted financial markets from private domestic savings mobilization.

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<sup>6</sup> Memorandum of the President of the International Development Association to the Executive Directors on a Country Assistance Strategy for the Republic of Senegal, pp. 4-5.

USAID, it must be emphasized, provides none of its health sector assistance through the GOS budget, and thus does not really encumber the GOS budget execution with any of its own aid procedures. In the health sector, through US and international CAs, USAID has provided significant direct funding over the years to decentralized Health Committees and other non-governmental and community-based organizations (NGO/CBO, 1992-1998 strategy) and to NGOs/CBOs as well as local government *collectivités* (1998-2006 strategy).

Instead of using USAID's "off-budget" approach, however, in order to decrease the "complexity of aid procedures," the World Bank, European Union, Canadians, and Dutch have recently decided to provide a portion of their assistance flows to Senegal as budget support rather than project funding. The Bank's budget support will include its assistance to the health sector, which was previously tied to a project. Funding by most of the donors will be tied – to a greater or lesser extent, depending on the donor – to Senegal's Medium Term Expenditure Framework (MTEF) under the Poverty Reduction Strategy Programme (PRSP). Senegal will additionally have increased untied external funding through its HIPC receipts.

**Given the anticipated increase in central revenue flows, there is thus no identified need for financial institutional support in the health sector.** Given USAID's very high disbursement rates "off-budget," and the complex requirements associated with direct USAID funding (e.g. through Implementation Letters), it is suggested that little benefit would accrue from such an effort. **Subject to further discussion with the MOH, USAID might more productively offer technical assistance to the MOH to help it disburse anticipated higher levels of funding expected from budget support and HIPC.**

*Should we work with people at a more senior level in the MOH?*

USAID has worked at different levels of the MOH and currently enjoys significant access to all division and department and central program heads at the central MOH as well as to Regional Medical Officers and District Medical Officers in focus regions. This level is certainly appropriate for week-to-week and month-to-month management needs.

**There are occasional needs for higher-level discussions on specific issues, e.g. policy formulation, major bottlenecks. USAID should establish some working relationship with the Secretary-General (or other key Cabinet member) to assure that these issues can be resolved in a timely manner.**

Given the more prominent position of the health sector within the MTEF, and the potential for increased resource flows for health from budget support and HIPC, USAID's Health Team should consider expanding these relationships to the Ministry of Decentralization and Ministry of Economy and Finance as well. (The Consultant notes that Col Ndiaye, in the 2002 Health Portfolio Assessment, offered a similar recommendation – ref. p. 49 of that Assessment).

- *What is the right mix of local versus central-level support?*

Table 1 in section 2.3 above shows the intended allocation of activities among three levels of intervention for the current strategy: local level services delivery, nationwide services delivery, and national level systems support. As of late 1999, the notional distribution of resources was to be about 25% to the national systems support, and 75% to services delivery at both levels. Table 2 in section 3.1 includes analysis of the allocation of FY 2004 funds between two levels – national and local -- and found that it was about 55-45, after adjustments for USAID management.

Available data and interviews with key informants suggest that successes have been greater with services delivery (focus districts and nationwide) than with systems support in the current strategy. **In hindsight, more attention to critical linkages between the local and national level might have led to better communications between the local and national levels, and more widespread results. The “right mix,” however, depends to a great extent on the activity/strategy objectives. In the case of the SO3 strategy from 1998-2006, key targets are being met and stated results are being achieved.**

- *What have been the results of donor coordination and what could be better?*

USAID and USAID’s implementing partners participate in numerous sectoral, topic-specific, and cross-cutting coordinative fora. The SO3 Health Team has until recently been less involved in donor groups addressing some broader issues that affect the health sector – e.g. PRSP, decentralized finance. **Given the shift in World Bank and EU financing to a budget support mode, however, the SO3 Health Team is now getting more actively involved in such fora.**

The SO3 Health Team also needs to collaborate with other donors as current instruments and relationships (geographic, institutional) are phased out in order to attract continued support to deserving partners. For example, the Belgians are launching a health program in Kaolack and Fatick in 2005, starting with one health district/region. They might prove a good partner to pick up funding of ARPV and/or some of the DISC momentum on local level planning. USAID should work with the Belgians and other donors, as appropriate, to pursue similar complementarities as the program evolves.

- *What has been our contribution to policy development, particularly in the areas of malaria, HIV, Maternal Health & Family Planning, and Child Survival? What key structural or policy issues have hindered or slowed our implementation efforts? Which key policy constraints could/should USAID address in the future, and how?*

Based on a decade of BASICS involvement, IMCI is now part of the standard package of healthy child interventions throughout Senegal. BASICS’ operations research under the current strategy on community-based cotrimoxazole presumptive therapy for acute respiratory illness (ARI) among children under 5 is in the process of being discussed for wider adoption by the MOH. BASICS and PREMAMA are also collaborating closely with the PNLP and Christian Children’s Fund, Africare, and Plan International on pilot testing of community-based sulfadoxine-pyrimethamine intermittent presumptive therapy for malaria. Finally, BASICS and PREMAMA fostered formation of, and are collaborating with, a National Committee on Newborn Health to identify specific interventions to decrease neonatal deaths. These newer areas all have strong potential for impact on child survival and are of great interest to the MOH. Most informants agree, however, that community-based ARI and “bi-therapy” malaria efforts will require extensive discussion and collaborative development of protocols, norms, standards, and training prior to more widespread application.

Similarly, after 20 years of investment, maternal health/family planning is also part of a standard package of services at all public SDPs. During the current strategy, PREMAMA staff and consultants shifted from traditional training to a formative supervision approach to assure that all Nurses in charge of Health Posts, midwives, and other relevant Health/Post and Center staff were provided in-service training/re-training on FP protocols, norms, and standards. Under the current strategy, PREMAMA expanded post-abortion care (PAC) and emergency obstetric care

to a wider range of providers. Both are expected to become part of the standard package of MH at all Health Centers that have appropriate infrastructure to implement them.

In collaboration with the MOH and the Ministry of Education, PREMAMA has fostered incorporation of integrated reproductive health package into the curriculum at all Teacher Training Institutes. This is an important step in broadening coverage and information. Unfortunately, to date IMCI is not similarly covered even in pre-service training of Nurses. This is an area overdue for policy attention.

FHI and other partners have provided critical assistance to the GOS' formulation HIV/AIDS protocols, norms, and standards for STI diagnosis and treatment, VCT, PMTCT (on-going), and ART. These inputs are highly valued and expected to continue as dictated by the nature of the epidemic and global advances in prevention and care.

USAID's support to social marketing of contraceptives has opened new territory for public-private partnerships over 20 years, and GOS agreement for distribution of oral contraceptives by non-medical personnel was ground-breaking. Similar incremental "demedicalization" is expected as injectables are market-tested in the future.

In contrast to USAID's long-term successes, after 20-plus years of support, USAID still provides the bulk of all contraceptives to Senegal, still develops the annual contraceptive procurement tables on behalf of the DSR, and still pays for and manages most public sector contraceptive distribution activities. **This is an area that USAID needs to strategically and deliberately turn over to the GOS.**

There are numerous other areas where, over time, **USAID has had a significant and positive impact on MOH policy. Several of the experiences mentioned above highlight that implementation of policy change is not a linear experience with a beginning, end, and well-identified steps along the way, but a rather "messy" set of exchanges, negotiations, and steps forward and back to build consensus and achieve incremental results. This reality should be kept at the forefront in terms of building expectations for impact in the future.**

## 4.2 Long-Term Capacity Building

- *Did all the expected stakeholders participate in planning, implementing, and monitoring the current strategy? Was institutional sustainability supported? Was financial sustainability promoted?*

Section 2.3.1 above summarizes the original intent of the "demand-driven" strategy and the shift to more standard USAID modes of operation. Because of this, there was no national level publicity campaign to solicit proposals, so in that case, it must be said that the originally expected stakeholders did not in fact participate in program planning. Section 2.3.1 concludes that:

... that there are certainly numerous health-related activities – notably water supply and some community-based initiatives, and perhaps some studies or operations research activities – that might have come to USAID's attention and been financed had a broader publicity campaign been undertaken. On the other hand, there are probably an equal number of activities that were undertaken with communities and community-based groups that might not have been financed had USAID-financed contractor/cooperating agency (CA)

staff not approached the community directly and provided orientation and training (*encadrement*) on public health. The Consultant's conclusion is that program implementation in fact included explicit mechanisms to solicit and respond to the expressed needs of communities and local governments within the parameters of USAID's funding earmarks and program regulations, and that much of the intent of the "demand-driven" CSP was met.

There remain questions as to sustainability at numerous levels. Several informants expressed concern about sustainability – technical, financial, and institutional – of many funded activities. For example, in terms of technical sustainability, the PREMAMA Interim Evaluation of November 2003 suggests that project gains in service quality and management and leadership are fragile and tenuous, with risk of being lost when project inputs end. (PREMAMA reoriented some approaches based on the Evaluation, and is addressing key issues raised). Similarly, the NGOs collaborating with BASICS and PNLP in operations research on community-based malaria therapy agreed that sustainability (technical) was dependent on the quality of the community provider (AEC or equivalent) and on the continued presence of a trained and pro-active referral/supervisory Nurse at the Health Post level, or continued engagement of an NGO or other partner. Key informants on Senegal's HIV/AIDS program emphasize that is still in an early learning curve, so that a critical mass of trained technicians and counselors does not yet exist to assure any responsibility. Although technical capacity is best addressed on a case-by-case basis, it affects institutional and program sustainability overall and merits continued attention.

In terms of institutional and financial sustainability, the strategy did not address more macro-level MOH planning and budgeting except at the health center and health post level. As stated above, particularly given anticipated increases in funds available for health due to World Bank and EU budget support and new HIPC inflows, there is significant room for collaboration so that the funds are put to efficient and effective use. The World Bank plans to provide some assistance to the GOS for overall decentralized finance, as part of the MTEF. USAID is encouraged to maintain its dialogue with the Bank and the GOS as plans progress.

At the health center and health post level, by design the DISC project collaborated with local officials and Health Committees, but did not involve itself with health facility management or efficiency. DISC efforts certainly contributed to expanding the knowledge of public health among public officials, and to date has assured some continued contribution of local resources to health. However, its long-term contribution in terms of domestic resource mobilization cannot be assessed until more districts have "graduated" from the Matching program.

It is at the community level where institutional and financial sustainability may have been best addressed, through *mutuelles* and a new community feedback tool; through community COPE; through extensive work by most projects with CBOs and FBOs; and through the ARPV initiative. There were some concerns that community outreach workers (*relais*) who had previously worked on a voluntary basis might have trouble returning to that voluntary basis should funding for ARPV cease. **There was widespread agreement that any attempts to strengthen capacity at the local level should be accompanied by an early and explicit exit strategy.**

- *What progress and pitfalls have been encountered in decentralizing the health system? What are the challenges? Has improved communication with elected officials let to results in terms of health objectives? What is the leveraging effect of the matching grants?*

Given the scope of this Assessment, the Consultant could not devote adequate time to an evaluation of overall progress and pitfalls of health decentralization. The comments that follow relate primarily to the DISC experience, and are informed by one day of interviews at a very limited number of decentralized sites.

In terms of progress, **DISC's greatest achievement was fostering widespread understanding of decentralization – health and administrative – and the new roles and responsibilities it implies, and much deeper understanding of what “public health” comprises.** DISC fostered dialogue between and among health officials, locally elected officials, civil servants, and community leaders. The Matching Grants were a tool – a carrot, as it were – to encourage the process. Had USAID undertaken a “decentralization knowledge, attitudes, and practices (KAP)” survey at DISC's entry and exit to health districts, it is generally believed that the post-project scores would be very high.

The deficit in the project design was that there was too little attention to fostering linkages with the central level, and no MOH (or other) systems to allow project-level learning to be disseminated. DISC worked with the *Division de Soins de Sante Primaire* (DSSP) within the Department of Health, but it had limited staff. DISC had virtually no relationship with the Ministry of Decentralization or the Ministry of Finance (except through the *Percepteur* at the municipal level). There was no HMIS or other information system to communicate project achievements to decision makers.

A second deficiency of the DISC design was the inadequate understanding of the lack of transparency of Health Committee management and operations, and of local resistance to change. DISC initially thought that it would act through the broader Management Committee (*Comité de Gestion*), which provides for broader membership and oversight of the Health Committee. DISC staff found, however, that newly elected Mayors in particular – there were local elections in 2002 -- were reluctant to insert themselves in existing Health Committee processes and possibly lose community support and goodwill. No Management Committees were formed or active in the USAID focus districts up to the time of this Assessment.

The DISC experience also highlights a more systemic deficiency with Senegal's decentralization structures, which is that re-grouping communities above the Rural Community level -- to have a stronger voice in advocacy, to achieve economies of scale necessary for maintaining selected services, etc. – is very difficult. The decentralization texts permit a number of such higher-order groups – e.g. *Groupeement d'Interet Communautaire (GIC)* – but these do not lend themselves easily to public health actions. Because the health referral system depends on economies of scale for many services, however, this is an area that merits continued attention.

DISC also encountered a more universal problem with decentralization, e.g. significant delays in release of annual budgets. Many of the municipalities in USAID focus districts only receive their annual budgets in October, which means they have only three months to spend everything. (This is not unlike the USG releasing funds in June that must be spent by September.) This compressed timeframe encourages corner-cutting on administrative procedures such as consultation and competitive procurement, with a consequent dampening effect on public confidence. The World Bank is working with the GOS on improving fiscal decentralization procedures as part of the MTEF, so this problem should be resolved in the next few years.

- *To what extent will communities develop and contribute to local health plans, without a matching grant?*

As stated above, Health Committees have shown some reluctance to engage in a fully transparent budget process. Given the MOH and GOS budgeting process, however, it is clear that local communities, through fee-for-service and other contributions (e.g. voluntary services, various *cotisation* schemes), already pay for the bulk of their personal and family health care. The GOS contribution at the health hut and health center level is generally limited to payment of civil service salaries, where civil servants are posted. Communities already cover all other costs through fee structures, and frequently supplement civil service salaries through provision of housing and/or modest incremental fees and volunteer time. The increasing use of private providers, in urban areas, and membership in *mutuelles* and other health insurance schemes in urban and rural areas indicate strong public contribution to personal and family health care.

The health planning process led by the DISC project has increased the awareness of the concept of public health among elected officials and community leaders. Interviews in one of the “graduated” health districts indicates that the local government contribution was 30-50% of what it had been with the DISC Matching Grant, which is still encouraging. Several of the graduated districts are still making health plans and budgets, without external assistance. Given the fact that Senegal’s Decentralization texts were only issued in 1996, progress to date is encouraging.

The discussion under “sustainability of decentralization” below includes a recommendation that USAID/Senegal undertake an external evaluation of local planning and budgeting experience. USAID had a “learning lab” in its DISC and DGL Felo Project (28 of the project’s 157 grants were for public health) and several USAID-support NGOs work extensively with local authorities on planning and budgeting (Africare, Christian Children’s Fund). This question on the extent of community participation in planning and their contribution could be answered more fully at that time.

- *Should USAID support decentralization in a separate health activity, as in the current strategy, or should decentralization be addressed through other technical areas, such as child survival or maternal health?*

The 1998-2006 SO was *Increased Use of Decentralized Health Services in Targeted Areas*. As described above, by design the BASICS, PREMAMA and DISC projects all contributed significantly to the objective, and the FHI, PHR-plus, RPM-plus, NETMARK, CEDPA, Africare, CCF, Plan International, PL 480, and other partners contributed to some extent. The BASICS, PREMAMA, and FHI contributions to development of technical norms and standards for each level of health services delivery – community, health post, health center, etc. – in malaria (ongoing), ARI (ongoing), neonatal, PAC, VCT, PMTCT are of particular note. DISC provided incentives for local governments to become involved, with particular achievements in increasing physical infrastructure – health huts, equipment – at the grassroots level.

A deficiency of the overall SO3 implementation strategy was the assumption that coordination of inputs among BASICS, PREMAMA, FHI, and DISC could be achieved through a consultative process. Indeed, Figure 1 at page 7 shows that the original design intended that each technical “menu of services” would be “... developed, costed, and promoted as part of local-level health care package.” Given less-than-anticipated coordination among the key CAs, however, the menus were never costed and BASICS and PREMAMA activities were included in annual plans without costs. Achievements of local level annual plans were never monitored and evaluated, except for expenditure of Matching Grants, so it is difficult to measure any benefit of collaboration. The lack of information on costs of basic services, and the lack of transparency of facility budgets of the Health Committees, resulted in the DISC planning support being primarily

“off-budget” items. A break-down of the Matching Grant resources for 2003, in fact, shows that almost 78% of funds went to basic infrastructure (rehabilitation and equipment) as opposed to health services.

Other “deficiencies” in design are addressed under “progress and pitfalls” above. **Given the experience, the Consultant does not recommend a separate “decentralization” instrument but rather encourages USAID to incorporate attention to decentralization as a cross-cutting theme in any health services and health finance efforts in future support.**

- *Can we predict the sustainability of the decentralization policy, and what are the key lessons learned from our extensive efforts at developing local health plans?*

The “sustainability of the decentralization policy” is a political consideration well outside of the manageable interests of the Health Team. The Consultant notes, however, that decentralization of services has been promoted throughout Africa for at least 15 years, and that many countries have learned lessons and moved ahead. For example, Mali’s experience with “the Bamako Initiative” beginning in 1987 led to the contractual process with rural health centers managed by local communities (the CS-COMs) that endure today. Senegal’s initial Decentralization texts were only issued in 1996, and their operationalization is still underway. The Consultant suggests it is unlikely that Senegal would re-centralize its administration or health services, but it is certainly too early to tell.

**USAID/Senegal’s efforts at development local health plans would benefit from an external evaluation by a team that includes specialists with experience in decentralized health care in other countries.** The evaluation should assess the on-going efforts of DISC, recent efforts of USAID’s DGL Felo Project (28 of the project’s 157 grants were for public health), on-going efforts of several NGOs with Health Committees (Africare, Christian Children’s Fund, Plan International), and possibly other donor-funded efforts. The evaluation might look at USAID’s efforts working with Health Committees on health planning under earlier strategies. “Lessons learned” could relate to appropriate point of entry (e.g., Health Committee, *Comité de Gestion*, other?), models of contractualization, planning and budgeting for health posts/centers, leadership development, etc.

- *How well are gender issues addressed in our projects? Do separate “gender” activities have an impact on achieving results? What is the best way to effectively address key gender issues, including early marriage and child birth, FGC and women’s autonomy for reproductive health decision making.*

The SO3 portfolio overall has done quite well at addressing women’s participation in activity planning, implementation, and monitoring. Indeed, most Health Committees are dominated by women (informants agree that women are frequently preferred as Treasurers) and the majority of health outreach volunteers (*relais*) are female. Mother’s Clubs, Grandmother’s Clubs, and other women-dominated CBOs predominate in most health-related community efforts. This balances well with the fact that most Nurses in charge of rural Health Posts and Mayors of Rural Communities are male, so that both points of view are represented in community activities.

The SO3 portfolio has done less well on involving men in critical family health concerns. The 2003 15 District Survey found that 7% of women cited that their husband/partner refused to let them use family planning, and 14% of women who discontinued a method did so on their husband/partners decision. The ESIS found that 29% of men cited religion (Islam) as a reason for not using family planning. Based on these and other data/experience, in 2004 PREMAMA

launched a “Men as Partners” effort and increased its work with Islamic organizations. Unless the 2005 DHS data show major differences in men’s influence on reproductive health decision-making, this effort and/or others like it should be candidates for continuation in the future.

There has been no parallel BASICS (or other child survival partner) “Men as Parents” or similar efforts. Given the documentation regarding men’s influence on their wives’ care-seeking behaviors, and given USAID’s particular concerns about maternal and neonatal mortality, it is suggested that some sort of IEC/BCC focus on men’s roles in child and family health might be explored and pursued in any future strategy.

Both CEDPA and FHI utilize sub-agreements for capacity building of women’s and youth organizations for advocacy, program management, and more generic civil society empowerment. CEDPA utilizes both Population and HIV/AIDS funds for these activities, and assures that its areas of emphasis follow funding. FHI works primarily in the HIV/AIDS arena. Both organizations see continuing need for more generic civil society advocacy and empowerment to complement technical health efforts.

**In summary, separate “gender” activities such as “Men As Partners,” “Men As Parents,” and work with Mother’s and Grandmother’s Clubs (for maternal health in particular) should be continued in any future strategy to that assure technical results in CS, MH/FP, and HIV/AIDS are achieved.** USAID should continue to assure that CAs provide training and other incentives equally to men and women during activity implementation, and should reinforce its efforts at sex-disaggregated monitoring and reporting. To the extent funds are available, continued more generic work with gender-specific or gender-targeting civil society groups -- NGOs and CBOs -- to increase capacity for advocacy and management would be useful.

### 4.3 Geographic Priorities

- *How should we select our geographic focal points for the next strategy? Are our current geographic areas the most appropriate? Do we have the capacity to operate so widely? Does including one district in Fatick still make sense?*

USAID/Senegal’s Health Team selected its focal districts for the 1998-2006 strategy based predominantly on pre-existing relationships in 29 health districts. This coverage was reduced to 21 health districts early in the strategy, due to budget constraints. As stated in the common background section used in the DISC, FHI, and MSH solicitations in 2000:

These regions are not new to a partnership with USAID. As well-documented in USAID’s Development Experience System (DEX, at [www.dec.org](http://www.dec.org)), USAID financed a rural health project in the Sine Saloum area -- Fatick Region -- in the late 1970s, and worked in Fatick and Kaolack through the 1980s. USAID’s health, population, and nutrition activities under its 1992-1998 strategy and current “transition activities” focused in the core regions ....

There are certainly strong management efficiencies obtained by staying in the same regions for decades and building on past experience, and pre-existing relationships should clearly be one criterion for selection of partners for a future strategy. **Until decisions are made as to the objectives of the next strategy, the Consultant cannot provide more specific advice on this question.**

- *What is the right balance of national activities (e.g. surveillance, social marketing, contraceptive distribution) versus select districts getting a fuller range of interventions?*

Table 2 in section 3.2 above shows that the FY 2004 allocation of resources, after subtracting USAID management costs, was about 55-45 for local level and national services delivery and systems support respectively. Discussions in section 4.1 and 4.2 above suggest that most informants believe that successes have been greater with services delivery (focus districts and nationwide) than with systems support in the current strategy. In hindsight, more attention to strengthening critical linkages between the local and national levels (e.g., systems support) might have led to greater dissemination of experience from the USAID focus regions to the national level and thence to other regions and districts, for possibly greater results.

However, **“systems strengthening” is notoriously difficult to measure**, so it is not clear to the Consultant what opportunities were lost. Section 4.1 above, under “policy measures,” identifies a number of areas where USAID has influenced important policy directions of the MOH over the past decade. There are also some outstanding deficiencies: one is the continuing reluctance of the MOH to take on contraceptive purchase and distribution management and costs, and a second is the lack of incorporation of new policies and standards such as IMCI into pre-service training curricula. **Section 6 includes recommendations to assure that fostering linkages between innovation and adoption is included in future programming.**

- *How closely should health activities be coordinated with other USAID/Senegal SOs? Should SOs aim to work in the same geographic regions? Are there areas, geographic or otherwise, where there have been useful synergies to maintain?*

**Informants to this Assessment identified a number of “lost opportunities” for synergy under the current strategy.** The DISC project Chief of Party, for example, stated that entry was easier in *collectivités* where the DGL Felo project had provided capacity building than in areas where DISC had to start from scratch. Given that 31.7% of DGL Felo small grants went toward public health projects, there was clearly perceived need on the part of participating local governments. DGL Felo also promoted several studies of the decentralized financial system which provide good insight into health allocations and planning; collaboration on joint studies and/or research might have proven fruitful for both SOs.

Several informants mentioned lost opportunities for potential collaboration between PRSO-supported microfinance lending programs and Health activities, e.g. women’s income generation, income-generation for PLWHA. There is strong potential in matching capable microfinance programs with private health providers to encourage entry to new geographic areas and/or new sub-sectors (e.g. loans for specialist laboratory or radiology equipment).

The Health Sector could definitely benefit from creative thinking on possibilities for Public-Private Partnerships to increase access and quality, as well as sustainable finance.

**Mission senior management is strongly encouraged to provide guidance and incentives to Health (and other) staff to assure such coordination and synergies are pursued more actively in the next strategy.**

#### **4.4 Specific Technical Emphases**

- *To what extent should youth, including adolescent reproductive health, be a focal point of USAID health activities?*

The 1999 ESIS reported that more than 57% of the Senegalese population is less than 20 years of age, which indicates that adolescents must be a focal point of health activities if USAID is to reach a large part of the population. The ESIS found that among women 20-24 years of age, 60% were already married, and that 17.6% of women 15-19 and 58.3% of women 20-24 were already mothers, with a median age of for all women of about 20 years for first birth. This strongly suggests that adolescent women, at a minimum, would continue to be strong candidates for reproductive health IEC, at a minimum.

The ESIS found that 20% of young men aged 15-19 years had occasional sex, and 15% had regular sexual partners. Overall, young men were found to be more prone to occasional sex than young women, indicating they are strong candidates for STI/HIV/AIDS prevention IEC/BCC.

[This does not mean that USAID needs to support a “Youth” SO or stand-alone “Youth” programs. However, the data do indicate that adolescents are sexually active singles, couples, and parents, and merit some focus in antenatal counseling and PMTCT; family planning; VCT; “Men As Partners”; and other CS, MH/FP, and STI/HIV/AIDS programs in the future.]

With USAID funding, FHI supports one VCT site at a stand-alone Youth Center, in a squatter neighborhood of Dakar. The site has higher utilization than most of the other sites – about 150 clients/month – of whom about 34% are between 10 and 19 years of age (about equal representation of men and women). This contrasts with an average of about 12% for that age group at the other 8 FHI-supported VCT centers. While these data are not surprising, given the location of the testing site in a Youth Center, they suggest a relatively strong demand for VCT exists among youth 10-19. FHI has obtained funding from the Japanese International Cooperation Agency (JICA) to support testing in an additional 8 youth centers beginning in 2005. It will be interesting to monitor their utilization rates as Senegal’s experience with VCT progresses.

The Consultant’s recommendation for future focus on youth is similar to that for gender, above. **Separate youth-targeted activities should be continued in any future strategy to that assure technical results in CS, MH/FP, and HIV/AIDS are achieved.** USAID should continue to assure that CAs provide training and other incentives equally to young men and women during activity implementation, and should assure that youth are targeted for training as appropriate. To the extent funds are available, continued more generic work with youth-specific NGOs and CBOs to increase civil society capacity for advocacy and management would be useful.

- *To what degree did the current strategy effectively work with the private sector? Should we focus more in the future on the private sector or the public health system?*

Discussion of “the private sector” in most countries needs to be disaggregated into four segments: i) private, non-profit organizations such as NGOs, CBOs, missions and faith-based organizations, membership associations, etc.; ii) private commercial health care providers, such as private doctors, clinics, laboratories, and pharmacies; iii) private commercial health care supporters, notably health insurance providers but also actors that manufacture or provide critical health inputs, such as insecticide treated bednets or pharmaceuticals; iv) large private employers who may become useful partners for worksite-based health programs. SO3’s relation with each of these segments is addressed briefly below.

It is emphasized that the Consultant did not have time to undertake a review of data on any of the four segments, so comments are brief and notional.

i) Private, non-profit sector: Informants stated that direct service provision by Senegal's private, non-profit health NGOs or other non-profits is relatively limited to Catholic mission facilities in a few sites. (This should be verified – there may be Islamic groups providing care, and or other non-profits). In general, private non-profit groups serve more as health care promoters or supporters than providers. At this level, **SO3 partners collaborate extensively with both international and national NGOs, FBOs, and associations in promotion of CS, MH/FP, and STI/HIV/AIDS services. This type of collaboration should be continued in a future strategy.** More information on the extent and type of coverage of private, non-profit organizations should be gathered to be sure they are included, as appropriate, in future activities.

Senegal has active professional associations of physicians, nurses, midwives, pharmacists, laboratory technicians, etc. The associations have proven useful partners in the past and should continue to be supported in the future, both in terms of health care and as key actors in Senegal's civil society.

It is noted that the relatively new ARPV, the PREMAMA community-based distributors, and many of the ADEMAs promoters fall loosely into the category of "private, non-profit sector." **The innovative contracting of ARPV as a non-profit organization in each Rural Community has important implications for sustainability. As Senegal's experience with contractualization in the health sector progresses, chances for similar institutional innovations may arise and should be investigated.**

ii) Private, commercial health care providers: Although current data were not available to the Consultant, the Director of Health at the MOH told the SO3 team that there are now more physicians practicing privately in Senegal than in the public health system. There are also numerous private nurses (often retired from public service) who operate small clinics in urban and some rural areas. It is generally believed that most of the private practitioners are based in Dakar and other urban areas.

Most of the current SO3 partners work with private commercial health care providers at some level. BASICS collaborates with RPM-plus to train Senegal's 550 private pharmacists in appropriate dispensing of oral rehydration solutions, Vitamin A, vaccines, ARI antibiotics, etc. ADEMAs works regularly with Senegal's private practitioners (number unknown) and 550 private pharmacists for sales of PROTEC condoms and SECURIL oral contraceptives, and will increase such contact when it begins sales of injectables in FY 2005-2006. ADEMAs provides training and IEC on its products to these private partners, and maintains the distribution and sales relationship.

In 2002-2003, PREMAMA staff collaborated with the District Health Office in Kaolack on a one-year pilot activity with 48 private practitioners in the district. PREMAMA nurtured formation of a *Collectif des Infirmiers Privées*, conducted a census, and carried out skill development through a series of workshops and training sessions in maternal health and family planning. During this time, reporting and referral mechanisms were developed between the *Collectif* and the Health District office.<sup>7</sup>

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<sup>7</sup> Pollock, John, et.al., Senegal Maternal Health/Family Planning Project (SM/PF) Interim Assessment, pp. 31-32.

At the end of the year, an assessment of all the *Privées* was made and official licenses of practice issued by the medical district. This served two purposes: 1. It assured that all those who were licensed had an appropriate level of quality in service delivery; and 2. It enabled the District to stop unqualified and incompetent practitioners from practicing. At present 16 of the original 48 are licensed and working closely with the district. They submit regular reports, make referrals to the district, and receive back-referrals. They have also begun to participate in the family planning program, and would be an ideal site for basing both *persuadeurs communautaires* and ARPVs in the community.

The project needs to consider replication of this initiative in all other smaller urban centers in the project area, and also needs to explore with the DSR and MSP [now MOH] as to how the licensing process could be adjusted to enable those *Privées* who don't currently meet the criteria can be brought to a standard where they can practice.

The above was written in November 2003. It is of interest that when the Consultant and SO3 colleagues visited the Kaolack Health District Medical Chief in March 2005, she reported that there were 12 private doctors and 14 private nurses in the group who were still reporting. {USAID might explore if the increase from 16 to 26 means that the District had established a means of training and licensing the practitioners, or if PREMAMA provided additional support.} The Medical Chief stated that the group no longer met because they no longer received per diem to do so. The SO3 team provided suggestions on innovative approaches, such as dinner-discussions, to involve the private sector without per diem involved.

PREMAMA is continuing to work with private providers as part of its evolving move toward a "Gold Star" certification program. However, its work is limited to maternal health/family planning, its own mandated area of operation. **Particularly in urban areas that comprise 45% of Senegal's population, private practitioners are an increasingly important segment of the health referral system. USAID should expand its collaboration with the MOH and/or regional and district partners in quality assurance and licensing of private practitioners to include CS and STI/HIV/AIDS as well as MH/FP in the future.**

lii) Private health care supporters: PHR-plus is the Health Team's major collaborator with the health insurance industry, although this has to date been focused on the non-profit side via support to individual and regional *mutuelles* and to two large social-professional organizations, l'UNACOIS in Dakar et Kaolack and the NGO Mouride Matlaboul Fawzaïni in Touba. **Given experience in other countries and potential MOH interest in such partnerships (e.g. the MOH cabinet-level cell on alternative finance), these relationships should be more systematically catalogued and assessed for expansion/replication. USAID should place particular emphasis on continued strengthening of *mutuelles* as well as other insurance and pre-payment schemes (see iv. Below) in the future.**

CNLS and FHI have successfully collaborated with international pharmaceutical firms, e.g. Pfizer, to nurture public-private partnerships for STI/HIV/AIDS drugs. ADEMAs and NETMARK also collaborate successfully with pharmaceutical wholesalers and other commercial supporters. The Mission should maintain contact with pharmaceutical firms and wholesalers as it develops its expanded public-private partnerships program in the future.

Other private health care supporters that have figured prominently in the USAID strategy include the media (radio in particular), private training facilities, and consultants. It is assumed these sorts of partnerships will continue under the future strategy.

iv) Worksite programs: The Consultant did not find specific mention of worksite programs – outside of schools and other training institutions -- in documents reviewed for this paper, and did not pursue worksite programs as a line of questioning during interviews. The Consultant assumes that ADEMAs and NETMARK both have sales representatives at large worksites throughout Senegal. **The SO3 Team should collaborate with USAID/Senegal staff working on competitiveness to assure that worksite-based health care (including direct services and/or insurance) is incorporated into new activities, as appropriate. The SO3 Team should also include worksites as potential “learning labs” for new innovations, e.g. worksite DOTS for TB.**

**Private Sector Conclusion: Private providers and supporters are key actors in Senegal’s health networks. USAID should include private providers and supporters in all future health activities on an equal, strategic and deliberate basis as public providers in CS, MH/FP, STI/HIV/AIDS, and health financing.**

- *In HIV/AIDS, have we supported priority interventions targeting high-risk groups? What portion of our future investment should go to these high-risk populations versus the general population? How much should be for VCT, PMTCT? How much for care and support? What is the right balance among these areas of investment?*

About \$500,000 per year of HIV/AIDS funding is for institutional support and capacity building for national sentinel surveillance and monitoring (*Hôpital Le Dantec*) and development/revision of national norms and protocols, training manuals, and formative supervision by the DLS (National AIDS Division). The balance of AIDS funding is provided for prevention and care and support programs undertaken by FHI; condom social marketing activities undertaken by ADEMAs; and some outreach/prevention/advocacy programs with women and youth undertaken by CEDPA.

The outreach programs supported by FHI focus primarily on high-risk groups – e.g. sex workers, transporters, fishermen, MSM, and PLWHA (est. 80-85% of sub-agreement resources). As stated earlier, because poverty is a key driver of the HIV/AIDS epidemic, FHI also undertakes capacity building for Senegalese NGOs who are addressing poverty through community-based interventions for the general populations (est. 15-20% of sub-agreement resources). More than half of ADEMAs’ condom social marketing is geared to high-risk groups.

**It is strongly emphasized that future, increased support for PLWHA and PLWHA groups for the full continuum of care and support at asymptomatic, symptomatic, and end-of-life stages of the disease is considered as part of “focus on high-risk populations.”**

In the future, USAID should plan to continue no less that \$500,000 per year as a base contribution for national programs (*Hôpital Le Dantec*, DLS), including formative supervision of public and private sector VCT programs. USAID should also maintain adequate technical assistance and support to the Division of Reproductive Health (DSR) and decentralized levels for training and formative supervision for counselors for PMTCT programs. USAID should plan to spend about 60% of outreach funds on prevention and about 40% on care and support of PLWHA. Of the prevention funds, approximately 15-20% should be maintained for support to Senegalese NGOs who address poverty reduction by community-based organizations. Of the care and support funds, no less than 20%-30% should be allocated to Counterpart International and CRS – tied to their eventual coverage -- to complement their P.L. 480 Title II resources allocated to care and support programs.

- *In child survival, can IMCI, EPI and nutrition activities be maintained with lower levels of USAID investment? What resources are required to maintain gains in these areas; can we move to more investment in community management and neonatal?*

As shown in section 3.1, USAID provides resources for IMCI, EPI and nutrition through numerous partners: BASICS, in the 21 focus regions and for national systems support; funding to polio vaccines in National Immunization Days through Africa Bureau transfers, and the agreements with Africa, CCF, and Plan International for community-based malaria and TB (which are considered as contributors to IMCI) in two additional regions. PREMAMA addresses neonatal care in collaboration with BASICS and Senegalese partners at central and decentralized levels. USAID's newer funding for ARPV mobilization efforts is also relevant. The USG additionally supports nutrition through the two P.L. 480 Title II agreements with Catholic Relief Services in Dakar and Counterpart International in Podor health district. **Given the wide range of coverage and resources provided for these activities under the current strategy, the Consultant was not able to formulate whether the activities could be maintained at lower levels or what levels would be required to maintain gains made.** The Consultant suggests that the partners involved could fruitfully address this question in more detail as strategy development progresses.

- *In line the with broader USAID strategy, USAID/Senegal has attempted to “reposition” family planning to improve the FP policy environment and to increase contraceptive security. How successful have these efforts been? Clearly, broadening access and improving the quality of family planning constitute major challenges for the future. How should USAID/Senegal seek to improve our efforts in this area?*

As mentioned under the policy discussion in section 4.1 above: “In contrast to USAID’s long-term successes, after 20-plus years of support, USAID still provides the bulk of all contraceptives to Senegal, still develops the annual contraceptive procurement tables on behalf of the DSR, and still pays for and manages most public sector contraceptive distribution activities. **This is an area that USAID needs to strategically and deliberately turn over to the GOS.**”

The Consultant defers to the wisdom of the SO3 staff who attended the recent Ghana workshop on “repositioning family planning” for broader information on this topic. **The Consultant suggests given the lack of GOS commitment after 20 years, increasing the proportion of resources to the private sector – for social marketing, NGO/CBO-led community-based distribution, and for private provision of clinical services – is a key strategy for consideration in the future strategy.**

- *USAID/Senegal has provided significant support for health financing through mutuelles. Is this an area we should continue to work in and how so? Should our support on health financing be limited to mutuelles or attempt to cover broader questions and issues? Is our investment in mutuelles achieving health impact? Do mutuelle members show increased use of critical health care services?*

As stated in the private sector discussion above, PHR-plus is the Health Team’s major collaborator with the health insurance industry, although this has to date been focused on the non-profit side via support to individual and regional *mutuelles* and to two large socio-professional organizations, l’UNACOIS à Dakar et Kaolack and the *Mouride Matlaboul Fawzaini* in Touba. **Given experience in other countries and potential MOH interest in such partnerships (e.g. the MOH cabinet-level cell on alternative finance), these relationships**

**should be more systematically catalogued and assessed for expansion/replication. USAID should place particular emphasis on continued strengthening of *mutuelles* as well as other insurance and pre-payment schemes in the future.**

There has been solid growth in USAID-facilitate *mutuelles*, from 8 *mutuelles* with 3,968 members in 2002 to 18 *mutuelles* with 10,878 members in 2004, reaching almost 45,000 family members. In 2004, PHR-plus developed feedback mechanisms to improve quality assurance and communication between facilities and *mutuelle* members, and restructured to provide less “hands-on” assistance to individual *mutuelles* and more strengthening to regional *mutuelle* associations.

There were no data available to the Consultant on the relationship between *mutuelles* and health outcomes, although it is likely that the PHR-plus team could obtain such data. It is suggested that use of the feedback mechanism developed during 2004 might serve to obtain such data.

**Given the uneven state of financing for public health services at decentralized levels, and widespread concern expressed over the sustainability of SO3 efforts, increased attention to health financing is indicated in future USAID work.** *Mutuelles* would continue to receive support within a broader and more systemic look at health insurance and pre-payment schemes overall. USAID could work with the “alternative financing” cell at the Cabinet level to examine and develop strategies and tools to address the many challenges in both the public and private sector health markets. Building on the DISC experience, there is much fruitful work to be continued to nurture involvement of *Comités de Gestion* and other mechanisms for greater oversight and management of public health in *Communautés Rurales*.

**Beyond the rural public sector and traditional USAID/Senegal activities such as *mutuelles*, however, there are other areas of health finance that merit attention.** One is the evolving market segmentation between/among private and public sector service providers. For example, is private-public balance really only urban/rural, or is there service segmentation that would indicate different types of support as well? Also, drawing from the PREMAMA experience with Gold Star, how should the Ministry approach more widespread quality assurance and licensing/ accreditation, not just for MH/FP but for CS and STI/HIV/AIDS as well? What should the relationship of local government be – if any -- to private providers within health networks/referral systems. Are there tax or other public finance incentives that could encourage private providers to enter new markets, smaller towns, etc? Are there more creative public-private partnerships that could be established through new contractual mechanisms?

For example, a somewhat critical need exists to examine the sustainability of the ARPV experience. An early idea was that ARPVs could be contracted by “other donors,” which in the Senegal context is certainly a good option. However, the average cost of ARPVs per district is only about US\$3,000/year, which should be affordable to local governments, strong *mutuelles*, international NGOs, and/or local private health supporters. A creative health financing approach might identify a number of different sources for financing ARPVs and other contracted health actors. The current WHO-inspired interest in “contractualization” is an area of health financing with much room to grow.

**The questions above, and others, point to a growing realization that USAID needs to work with both public and private providers as key actors in health networks/referral systems if USAID is to increase use of decentralized health services on a sustainable basis.**

## 4.5 USAID Implementation Strategy

- *USAID/Senegal currently supports a number of largely vertical programs, often using Global Health Bureau mechanisms. Should our future instruments be integrated or vertical? Grants or contracts? Bilateral or central? Are there technical domains in which centrally funded projects are advantageous?*

**These questions cannot be answered until the SO3 Team determines what it wants to accomplish.** In general, in the past the Agency recommended use of pre-competed instruments where possible. If this recommendation is followed, use of Global Health Bureau mechanisms would be indicated. If the Agency is promoting “new partners,” then competitive bilateral procurements would be more indicated. Global Health mechanisms could be accessed either through centrally managed Field Support or through bilateral actions (depending on the mechanism). The question of “integrated or vertical” would depend on the objectives and technical domains selected. The question of grants or contracts should be discussed with the Regional Contracts Officer.

- *Do we have too many mechanisms (and partners) in our current strategy? How can we streamline our program, particularly in light of possibly diminishing financial resources? If we continue to support a large number of partners, how can we ensure incorporate collaboration or synergy so that implementers will not view time spent on collaboration as an extra or secondary responsibility?*

**This question would be answered once the SO3 Team determines what it wants to accomplish in the future.** There is great potential for leveraging other funds – budget support, HIPC, private sector – to achieve results, but this sort of work may be management intensive. Coordination does take time, however, and needs to be included as a task in contracts (as it was in the current strategy) so that implementers do not view time spent as an extra responsibility.

## 5. LESSONS LEARNED

USAID’s use of the term “lessons learned” is generally related to more detailed project and program evaluations than has been possible with this short Assessment. Some very summary, cross-cutting ideas for incorporation in the new strategy follow.

- To achieve systemic change, a new strategy should include specific measures to build critical linkages between the local and national level. One approach would be to utilize multiple points of entry – local, district, regional, national, government, non-government – to address carefully defined problem areas.
- Health sector problems cannot all be addressed within the health sector alone. USAID’s SO3 Health Team much expand its dialogue with other ministries (e.g. Decentralization, Finance); other actors (e.g. private providers, private supporters); and other donors to assure that problem areas are adequately understood and interventions are appropriately designed to address them.
- The whole is often greater than the sum of the parts (Pythagoras). In terms of USAID/Senegal’s health program, this means that the SO3 Health Team should work to

bring all available USG resources to bear to address identified health problems. This would include explicit provision for inter-SO collaboration with other USAID programs. This includes continued close collaboration with West Africa Regional Programs and Global Health Bureau efforts that effect Senegal. It would also include provision of some dollar resources (through an APS-generated grant) to complement P.L. 480 Title II partner programs in health and HIV/AIDS. Finally, SO3 should participate in USG reviews and discussions as Senegal's MCC proposal moves ahead.

- Periodic external evaluations and more analytic documentation of results help USAID teams manage for results. Although the SO3 Team is proud of its program, given the lack of documentation it is difficult to disseminate the results or to infer or demonstrate impact. Presumably the DHS will provide data on technical achievements. More topical and qualitative evaluations should also be considered.

## **6. STRATEGIC OPTIONS FOR CONSIDERATION**

### **6.1 Form**

Given the fluidity of USAID guidance on country strategic plans, the Africa Bureau has advised USAID/Senegal to delay development of a new strategy to begin in 2007. The Mission has thus decided that the SO3 team will move ahead on development of some new implementation instruments, with possibly new proportional emphases, within its current strategic framework. There are no other options to discuss at this time.

### **6.2 Substance**

Given the decision to work within the existing strategy, the SO remains: *Increased Use of Decentralized Health Services in Targeted Areas*, including three Key Intermediate Results (KIRs) and ten related subsidiary IRs:

#### **KIR-3.1 Improved access to quality child survival, maternal health, family planning, and sexually transmitted diseases/AIDS services**

- IR 3.1.1 Functionality of existing public health SDPs improved.
- IR 3.1.2 Network of private sector SDPs expanded.
- IR 3.1.3 Coordination between public and private sector services improved.
- IR 3.1.4 Program management and technical monitoring of public and private sector services improved.

#### **KIR 3.2 Increased demand for quality child survival, maternal health, family planning, and sexually transmitted diseases/AIDS services.**

- IR 3.2.1 Increased knowledge of the benefits of CS, MH, FP, and STI/AIDS services.
- IR 3.2.2 Increased participation of opinion leaders (religious, political and civil) in social mobilization.
- IR 3.2.3 Private sector information-education-communications (IEC) activities expanded.

#### **KIR 3.3 Increased financing of health services from internal sources.**

- IR 3.3.1 Total local and central government resources allocated to health increased in real terms.
- IR 3.3.2 Total non-government resources allocated to health increased;

IR 3.3.3 A monitoring system for the legal and regulatory framework for health made functional.

Drawing from Table 2 at page 8 and review of earlier fiscal year data, KIRs 3.1 and 3.2 absorbed about two-thirds (66%) of the resources in the current strategy, with KIR 3.3 at about 20%, and USAID management and “other” making up the balance.

Sections 3 and 4 above suggest that access to quality health care has expanded during the course of the strategy (IR3.1.1), but that participation of private sector providers, and public-private partnerships (IRs3.1.2 and 3.1.3) have not proceeded as quickly. Program management and monitoring of both public and private providers (IR3.1.4) still needs significant attention.

**USAID should increasingly withdraw from support to routine services and focus increasingly on innovative solutions to critical problems. This focus would comprise developing/adapting technology packages, nurturing formulation of necessary policy reforms, and promoting development of protocols, norms, standards, training curricula, etc. to implement the innovations.**

In terms of demand, the consultant did not assess knowledge (3.2.1) and suggests that the DHS will provide more current and accurate information. There was general agreement among informants that more could be accomplished with civil society groups, opinion leaders, and “champions” (IR3.2.2) to stimulate demand for quality, through community COPE, use of citizen oversight committees (e.g. Management Committee) and other feedback mechanisms. There are continuing concerns about increasing knowledge and health behaviors for HIV/AIDS. There is an as-yet-untapped network of private providers for all technical domains who could help increase access and demand (IR 3.2.3). **Section 4.3 – 4.4 in particular includes recommendations in this regard.**

**In terms of health financing, sections 4.1 and 4.4 above provides additional information and recommendations.**

**The Consultant recommends that USAID consider readjusting resource allocations over the FY 2006-2007 period to proportionately reduce funding for access and demand (KIRs 1 and 2) and increase funding for finance (KIR 3) to carry out some of the recommendations in section 4 of this Assessment.**

The technical domains would continue to represent Senegal's reproductive health priorities as expressed in the PNDSS-II and PDIS-II, including child survival (to include malaria), maternal health/family planning, STI/HIV/AIDS, and health financing. Attention to tuberculosis should be integrated to the extent possible into a minimum package of care, and increased emphasis on community- and/or worksite-based DOTS should be pursued. A preliminary listing of specific areas to address through innovative means would include:

- Community-based treatment of pneumonia.
- Community-/worksite-based presumptive treatment of malaria.
- Community-/worksite-based TB-DOTS.
- A new neonatal care package.
- A new post-partum hemorrhage package.
- Prevention of mother-to-child transmission of HIV, at all health centers.
- Cost effective VCT expansion (including mobile satellite testing).
- Emergency obstetric care at health centers with operative capability.

- Post-abortion care at hospitals and health centers with operative capability.
- Sustainable sales of ITNs (market segmented).
- Contraceptive security (method mix, availability, finance).
- Licensing/accreditation of private providers for CS, MH/FP, STI/HIV/AIDS.
- Alternative health financing: *mutuelles*, pre-payment schemes, classical insurance, etc.
- National Health Accounts and increasing efficiency of public investment (if not covered by other donors)

These problem areas would align well with the new “USAID Program Components” that will be the foundation of forthcoming strategic guidance:

- Build Health Systems Capacity
- Improve Child Survival, Health And Nutrition
- Improve Maternal Health And Nutrition
- Prevent And Control Infectious Diseases Of Major Importance
- Reduce Transmission And Impact Of HIV/Aids

**In this problem-centered strategy, if USAID did not support routine service delivery it could gradually phase out of “USAID focus districts.”** This would theoretically reduce CA management costs and free up funds for higher-impact activities.

**Instead, the technical domains could be addressed on a “market segmented” or “population segmented” basis.** For example, depending on the results of the DHS it is assumed that Dakar and other urban areas will have much higher – approaching a “critical mass” – contraceptive prevalence rate, and there would be much higher return to future USAID investment to invest the larger share of future family planning funds in urban and peri-urban, private sector approaches. Similarly, there appears to be market segmentation with ITNs underway. USAID might undertake an assessment of the dynamic and invest where there appears to be the highest potential return for the investment. PMTCT is naturally targeting, and HIV/AIDS VCT and prevention should emphasize high-risk groups. As stated earlier, a large share of HIV/AIDS care and support funds should target PLWHA throughout the continuum of care, at asymptomatic, symptomatic, and end-of-life stages of the disease. All of these problem areas/programs would be “market-segmented” or “population-segmented” and not tied to any “USAID districts.”

**There would be no particular focus on “decentralization” as a stand-alone topic.** As stated under “lessons learned” above, to achieve systemic change, a new strategy should include specific measures to build critical linkages between the local and national level. One approach would be to utilize multiple points of entry – local, district, regional, national, government, non-government – to address carefully defined problem areas. Local administrations would be one of many actors in each problem area/system to be addressed, and would have different contributions and needs to address each.

**ANNEX A**  
**STATEMENT OF WORK**

## **ANNEX A: Revised Statement of Work for Assessment and Design of USAID/Senegal Health Portfolio**

### **I. Background:**

USAID/Senegal is currently operating under its FY 1998-2006 Country Strategic Plan, which includes Strategic Objectives (SOs) in private sector development, democracy and governance, health, and education, and a Casamance Special Objective to promote peace and economic development in that region. Activities in agriculture and natural resources management are also undertaken through the private sector and democracy SOs.

The USAID/Senegal SO for health is **increased use of decentralized health services in targeted areas**. The Mission's health portfolio includes activities in the areas of child survival, maternal health, family planning, HIV/AIDS and STIs, malaria and TB, decentralization, health financing, and gender. The major implementing partners of these activities include MSH, FHI (IMPACT), Abt Associates (PHR+), CEDPA, ADEMAS (Agence pour le développement du marketing social), Partnership for Child Health Care, Inc. (BASICS III), and Development Associates. Other grantees include Plan International, Christian Children's Fund, and Africare. In addition to PHR+, USAID works with several US-based AID/W Grantees including NetMark, RPM+ and USPharmacopia. Implementing partners are encouraged by the Mission to coordinate and integrate activities wherever possible and appropriate. The Mission's health activities are implemented with 149 communities in 21 health districts in Thies, Kaolack, Louga, and Ziguinchor. Approximately 60% of Senegal's population resides in these districts.

Since 1997, the Government of Senegal has been in the process of decentralizing several sectors, including health. The Mission, through its current strategy, has worked to support the decentralization process, including through its health SO. Within the decentralizing health system in Senegal, USAID health activities have had some positive achievements in recent years. Some of these include:

- In 2003, 67% of children living in USAID-assisted health districts were fully immunized, up from 42% in 1999.
- A pilot activity has shown that community treatment of ARI in children under five can be carried out appropriately and correctly by trained and supervised Community Health Workers, and this activity has potential for future scale up.
- Use of modern contraception has increased from 6% in 1999 to 9.8% in 2003 in USAID-assisted health districts, and nationwide couple-years of protection increased by 11% between 2002 and 2003.
- A package of essential newborn care was implemented at both the facility and the community levels, involving key partners at the national and regional levels. The strategies achieved good results, in terms of decreasing neonatal mortality, and set the stage for rapid national implementation and scale-up.
- Increasing numbers of Senegalese are members of mutual health organizations, and because of this have greater financial access to a full range of health services. Mutual health organizations have benefited from USAID support.
- HIV prevalence in Senegal remains very low at approximately 1.5%.
- Gains have been made in malaria; with USAID and CDC-sponsored research and support, Senegal's Ministry of Health has adopted the policies of intermittent preventive treatment (IPT) of malaria in pregnant women and combination therapy (Sulfadoxine-pyrimethamine + Amodiaquine) for malaria treatment.
- USAID activities support community health planning and budgeting, along with matching grants for implementing community health plans in 149 communities. The matching fund mechanism has ended in 24 communities in the three original health districts. The process has led to greater involvement of civil society and increased communication between locally elected officials (mayors) and local health authorities.

A Demographic and Health Survey (DHS) for Senegal is currently underway. The modules being measured include reproductive health; family planning; childbearing, postnatal care, and breastfeeding; vaccination, child health, and nutrition; marriage and fertility; anemia; STI, HIV/AIDS, and FGC; and maternal mortality. Preliminary results are expected in June 2005.

#### **Information sources**

- Annual Supplemental Survey (November 2003)
- Senegal DHS (1997) and 2005 (to be completed)
- 1999 Health Indicator Survey
- USAID/Senegal Annual Reports
- USAID/Senegal Health Portfolio Assessment (POPTech, July-September 2002)
- Senegal National Health Development Plan and recent Annual Review Report
- Project reports from implementing agencies, and UN Agency partners
- Key informant interviews and group discussions
- Project site visits

#### **II. Objectives:**

To conduct an external assessment of USAID/Senegal's health portfolio, including project efforts and achievements since FY 2000. The assessment will be followed by the drafting of a design/implementation plan for future investments. The assessment and design plan are expected to be completed by June 2005.

#### **III. Purpose of the assignment:**

The purpose of this assessment/design is to examine efforts under the current health strategy (since 2000) and to assist the Mission in and planning USAID's future investments in health in Senegal.

#### **IV. Scope of work:**

##### **Required tasks and work plan**

Over the course of the assignment, the consultant shall work on the following tasks:

<b>Tasks</b>	<b>Time (weeks)</b>	<b>Timeline for completion</b>
<i>Initial Assessment/Strategy Options Paper</i> Review background documents, travel days, meetings, field visits, drafting paper, debriefing and incorporating feedback	16 work days	NLT March 30, 2005
<i>Development of Design/Implementation Plan</i> A&A planning and budgeting, developing overall design, some fieldwork to examine more details of what works at implementation level.	18 work days	NLT June 30, 2005
<b>Total</b>	<b>34 work days</b>	

##### **Methodology of the assignment**

Information should be collected through interviews with USAID/Senegal, including the USAID Director, the Health team and staff from other strategic objectives and offices. Interviews should also be conducted with implementing partner staff and Government of Senegal counterparts. The consultant will be required to review relevant documents, such as those listed above, as well as materials produced by USAID implementing partners in specific projects. The consultant may undertake site visits to certain health activities in the regions of Senegal supported by USAID. In the course of the assessment, and the design/implementation plan, the consultant is expected to work closely with the USAID/Senegal health team.

##### **Issues to be investigated**

The contractor will be required to investigate specific issues (raised by Mission and implementing agency partner staff) during the initial review or during design and implementation planning including:

*Issues related to Government of Senegal and Ministry of Health:*

- Why has there been less GOS/MOH involvement than expected in the process USAID/Senegal uses to implement health programs?
- How is USAID/Senegal's support of the GOS/MOH perceived? Do we need a more harmonized and formalized approach? Should we consider institutional support? Set aside money for public sector operations such as logistics and transport? Should we follow the lead of other donors and consider non-project assistance?
- Should we work with people at a more senior level in the MOH? What is the right mix of local versus central-level support?

What have been the results of donor coordination and what could be better?

- What has been our contribution to policy development, particularly in the areas of malaria, HIV, Maternal Health & Family Planning, and Child Survival? What key structural or policy issues have hindered or slowed our implementation efforts? Which key policy constraints could/should USAID address in the future, and how?

*Issues related to long-term capacity building:*

- Did all the expected stakeholders participate in planning, implementing, and monitoring the current strategy? Was institutional sustainability supported? Was financial sustainability promoted?
- What progress and pitfalls have been encountered in decentralizing the health system? What are the challenges? Has improved communication with elected officials led to results in terms of health objectives? What is the leveraging effect of the matching grants? To what extent will communities develop and contribute to local health plans, without a matching grant?
- Should USAID support decentralization in a separate health activity, as in the current strategy; or should decentralization be addressed through other technical areas, such as child survival or maternal health? Can we predict the sustainability of the decentralization policy, and what are they key lessons learned from our extensive efforts at developing local health plans?
- How well are gender issues addressed in our projects? Do separate "gender" activities have an impact on achieving results? What is the best way to effectively address key gender issues, including early marriage and child birth, FGC and women's autonomy for reproductive health decision making ?

*Issues related to geographic priorities:*

- How should we select our geographic focal points for the next strategy? Are our current geographic areas the most appropriate? Do we have the capacity to operate so widely? Does including one district in Fatick still make sense? What is the right balance of national activities (e.g. surveillance, social marketing, contraceptive distribution) versus select districts getting a fuller range of interventions?
- How closely should health activities be coordinated with other USAID/Senegal SOs? Should SOs aim to work in the same geographic regions? Are there areas, geographic or otherwise, where there have been useful synergies to maintain?

*Issues related to specific technical emphases:*

- To what extent should youth, including adolescent reproductive health be a focal point of USAID health activities?

- To what degree did the current strategy effectively work with the private sector? Should we focus more in the future on the private sector or the public health system?
- In HIV/AIDS, have we supported priority interventions targeting high-risk groups? What portion of our future investment should go to these high-risk populations versus the general population? How much should be for VCT, MTCT? How much for care and support? What is the right balance among these areas of investment?
- In child survival, can clinical IMCI, EPI, and nutrition activities be maintained with lower levels of USAID investment? What resources are required to maintain gains in these areas; can we move to more investment in community management and neonatal?
- In line with the broader USAID strategy, USAID/Senegal has attempted to “reposition” family planning, to improve the FP policy environment and to increase contraceptive security. How successful have these efforts been? Clearly, broadening access and improving the quality of family planning constitute major challenges for the future. How should USAID/Senegal seek to improve our efforts in this area?
- USAID/Senegal has provided significant support for health financing through *mutuelles*. Is this an area we should continue to work in and how so? Should our support on health financing be limited to *mutuelles* or attempt to cover broader questions and issues? Is our investment in *mutuelles* achieving health impact? Do *mutuelle* members show increased use of critical health care services?

*Issues regarding USAID's implementation strategy:*

- USAID/Senegal currently supports a number of largely vertical programs, often using Global Health bureau mechanisms. Should our future instruments be integrated or vertical? Grants or contracts? Bilateral or central? Are there technical domains in which centrally funded projects are advantageous?
- Do we have too many mechanisms (and partners) in our current strategy? How can we streamline our program, particularly in light of possibly diminishing financial resources? If we continue to support a large number of partners, how can we ensure incorporate collaboration or synergy, so that implementers will not view time spent on collaboration as an extra or secondary responsibility?

## **Deliverables**

The contractor shall submit Jennifer Adams at USAID/Senegal all the documents listed below. The documents shall be in English and in French in electronic format (e-mail or disk in Microsoft Word). If delivered by e-mail, send to [jeadams@usaid.gov](mailto:jeadams@usaid.gov).

1. **Assessment.** The consultant will produce a comprehensive assessment/strategic options paper that addresses the achievements of USAID/Senegal in the health sector since 2000. The assessment will help USAID/Senegal to determine whether its efforts in the health sector have been productive and successful, and help guide the development of new directions in the next phase of USAID assistance to Senegal. The report should be in English, and should not exceed 40 pages. **Due: NLT March 30, 2005.**
2. **Design Plan.** Based upon the findings of the assessment, and dialogue with USAID and its partners in Senegal, including the Ministry of Health, the consultant will develop a design plan that orients future directions of USAID's health assistance in Senegal. The plan should include reference to specific sub-sectors of health assistance, and include implementation mechanisms and illustrative budgets. The plan will advise USAID on vehicles for future activities (i.e., contract or grant; number and scope of projects; use of bilateral versus global mechanisms) and will

include a design calendar or timeline. Following USAID/Washington approval of the Mission's new multi-year strategy (expected March-April 2005), consultant will work with USAID/Senegal to incorporate produce any AID/W feedback and instructions. **Due: NLT June 30, 2005**

Prior to drafting the reports, the contractor shall submit his/her suggested outlines for USAID's approval.

Debriefing meetings will be held at periodic intervals during the time of the assessment work. In these meetings, the consultant will present preliminary findings and recommendations to Mission staff (health team and possibly other staff). At a debriefing meeting following the initial assessment, USAID/Senegal will provide initial feedback.

#### **V. Period of performance/Work Schedule:**

The assessment/strategic options paper, and design plan are expected to be produced by June 2005, though the consultant will not be required continuously on a full-time basis through this time period. The assessment should be completed before the end of March, 2005; and the design plan by the end of June, 2005.

#### **VI. Required Personnel/Desired qualifications**

USAID/Senegal considers that the contract requirements can be accomplished by one bi-lingual consultant working alone. However, the consultant is free to identify and engage local technical assistance in the accomplishment of this SOW, if desired.

The following skills and qualifications are required:

- Fluency in French
- Experience in assessment of health portfolios or strategies
- Extensive knowledge of USAID programming and processes
- Significant experience in program/project design
- Extensive experience in drafting USAID procurement mechanisms
- Excellent analytical and writing skills
- Past performance

#### **VII. Logistical Support:**

The assignment is based in Dakar, Senegal, with travel expected for field visits to projects. USAID/Senegal will provide office space and access to office equipment (printer, copier, fax, telephone) for the consultant's use. Local transportation to meetings will be provided by USAID Motorpool. A TDY villa at USAID will also be provided. Mission staff will assist with scheduling meetings and appointments with implementing partners and other key informants.

#### **VIII. Evaluation criteria**

The following skills and qualifications are required:

- |   |           |
|---|-----------|
| • Fluency in French   | 20 points |
| • Experience in assessment of health portfolios or strategies   | 40 points |
| • Extensive knowledge of USAID programming and processes        | 40 points |
| • Significant experience in program/project design              | 20 points |
| • Extensive experience in drafting USAID procurement mechanisms | 40 points |
| • Excellent analytical and writing skills                       | 40points  |
| • Past performance  | 50 points |

TOTAL	250 points
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**ANNEX B**  
**LIST OF PERSONS CONTACTED**  
**&**  
**SCHEDULE**

**ANNEX B**  
**LIST OF PERSONS CONTACTED & SCHEDULE**

Wed Mar 2	04:00  09:00 – 10:00	Airport  USAID	Arrival  <i>USAID In-Briefing:</i> <ul style="list-style-type: none"> <li>• Jennifer Adams, SO3</li> <li>• Brad Barker, SO3</li> <li>• Mamadou Ndaw, SO3</li> </ul>
Thu Mar 3	08:30 – 10:30	USAID	<i>Joint Work Session, USAID Team</i> <ul style="list-style-type: none"> <li>• Lisa Franchett, PRM</li> <li>• Brad Barker, SO3</li> <li>• Mamadou Ndaw, SO3</li> <li>• Matar Camara, SO3</li> <li>• Rama Dioume, SO3</li> <li>• Goura Niang, SO3</li> <li>• Sounka Ndiaye, SO3</li> <li>• Bissenty Correa, SO3</li> <li>• Ellen Wertheim, SO3</li> </ul>
	10:30 – 12:30	USAID	<i>Partners Discussion</i> <ul style="list-style-type: none"> <li>• Soukaye Dieng, CEDPA</li> <li>• Dr. Seynabou Mbenggue Sow, ADEMAS</li> <li>• Dr. Francois Pathé Diop, PHR+</li> </ul>
	14:00 – 15:00	USAID	Kevin Sturr, Food For Peace
Fri Mar 4	09:00 – 12 NOON	USAID	<i>Partners Discussion</i> <ul style="list-style-type: none"> <li>• Dr. Thiam, BASICS</li> <li>• Barbara Sow, FHI</li> <li>• Ousmane Faye, MSH</li> <li>• Vicente Joret, DA</li> </ul>
	13:00 – 14:00	USAID	• Erin Soto, A/DIR
Sat – Sun Mar 5-6			Documents review; drafting
Mon Mar 7	08:30	MOH-RH Div	• Dr. Mbaye, MOH Chief of Reproductive Health Division
	10:00	CNLS	• Dr. Ndoye, Executive Secretary, CNLS
	12:00	DSL	• Dr. Wade, MOH AIDS Division Chief
	15:00	DANSE	• Dr. Valerie, Chef de Bureau Nutrition, DANSE, et Dr. Diouff

	16:00	MOH	<ul style="list-style-type: none"> <li>• Dr. Babacar Dramé, National Director of Health</li> </ul>
Tue Mar 8	08:30	MOH Malaria	<ul style="list-style-type: none"> <li>• Dr. Thion, PNLP Coordinator</li> </ul>
	10:00	MOH TB	<ul style="list-style-type: none"> <li>• Dr. Sek, PNT Coordinator</li> </ul>
	12:00	WB	<ul style="list-style-type: none"> <li>• Julie Vandomelan, World Bank</li> <li>• Aissatou Diack, World Bank</li> </ul>
	15:00	WHO	<ul style="list-style-type: none"> <li>• Drs. Farba Sall &amp; I Toure</li> </ul>
Wed Mar 9		Kaolack Thies	<ul style="list-style-type: none"> <li>• 09:00 – 10:00 Dr. Mama Coumba Faye Diouf, District Medical Officer, Kaolack</li> <li>• 10:00 – 11:00 Moussa Ndiaye, Nurse, Gandiaye</li> <li>• 11:30 – 12:30 Dr. Issa Mbaye, Regional Medical Officer, Kaolack, and his team</li> <li>• 14:00 – 15:00 Municipal Secretary, Gandiaye</li> <li>• 15:00 – 15:45 Health Committee, Gandiaye</li> <li>• 16:30 – 17:30 Dr. Sounka Sow, District Medical Officer, Thiadiaye</li> </ul>
Thu Mar 10	14:00 – 16:00	USAID	<i>Joint Work Session, USAID Team</i> <ul style="list-style-type: none"> <li>• Jennifer Adams, SO3</li> <li>• Brad Barker, SO3</li> <li>• Mamadou Ndaw, SO3</li> <li>• Matar Camara, SO3</li> <li>• Elisabeth Benga-De, SO3</li> <li>• Rama Dioume, SO3</li> <li>• Ellen Wertheim, SO3</li> <li>• Sounka Ndiaye, SO3</li> <li>• Bissenty Correa, SO3</li> <li>• Goura Niang, SO3</li> </ul>
	13:00	USAID	<ul style="list-style-type: none"> <li>• Adbul Wahab Ba, SO2</li> </ul>
Fri Mar 11	11:00 – 12:30	USAID	Partners Discussion (Malaria & TB) <ul style="list-style-type: none"> <li>• Diaguily KOITA, Plan International</li> <li>• James R. Dean, Africare</li> <li>• Ikupa J. Akim, Africare</li> <li>• Ndeye Wade Diop, CCF/CAMAT</li> </ul>

Sat – Sun Mar 12-13		Hotel	Drafting
Mon Mar 14	10:00 – 12:00	USAID	Partners Discussion (PL 480) <ul style="list-style-type: none"> <li>• Lisa Sow, Catholic Relief Services</li> <li>• Josephine Trenchard, Counterpart</li> <li>• Laura Rudert, Counterpart</li> <li>• Medoune Diop, Counterpart</li> <li>• Youssouf Sawadogo, Counterpart</li> </ul>
Tue Mar 15	TBD	USAID	10:30 – 11:30 Discussion with: <ul style="list-style-type: none"> <li>• Erin Soto, A/DIR</li> <li>• Lisa Franchett, PRM</li> <li>• Jennifer Adams, SO3</li> <li>• Bradley Barker, SO3</li> </ul>
Wed Mar 16		Hotel	12:00 – 1:00 Work session with: <ul style="list-style-type: none"> <li>• Bradley Barker, SO3</li> <li>• Mamadou Ndaw, SO3</li> <li>• Matar Camara, SO3</li> <li>• Elisabeth Benga-De, SO3</li> <li>• Rama Dioume, SO3</li> <li>• Ellen Wertheim, SO3</li> <li>• Bissenty Correa, SO3</li> <li>• Goura Niang, SO3</li> </ul>
Thu Mar 17		Hotel	Drafting
Fri Mar 18	<b>Submission Del. #1, Assessment/Strategic Options</b>		
Sat Mar 19	Dep. DKR 03:30 AM, via JFK, arr. MIA 12:37 PM		

**ANNEX C**  
**SELECTED DOCUMENTS REVIEWED**

## SELECTED DOCUMENTS REVIEWED

ADEMAS, *Marketing Social des contraceptives au Sénégal RAPPORT D'ACTIVITES Période du 1<sup>er</sup> janvier au 31 août 2004.*

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Décentralisation et Initiatives de Sénégal Communautaire (DISC), *RAPPORT ANNUEL 2002 PROJECT DISC*, version finale - SKe.

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- Plans d'Opérations des Collectivités locales (POCL), Synthèse des contribution par Accord de financement, 14/03/2005
- Comité de Planification et de Suivi du POCL (proposé pour la planification des POCLs 2004) versions 27/06/2003
- Equipes Communautaires de Santé (ECS) (élargies pour la planification des POCLs 2003), version 29/07/2002
- Justification du Comité de Planification et de Suivi du POCL, version 27/06/2003.
- Etat cumulé dépenses dans Districts sanitaires sur Po 2001-2002-2003, période du 1er Janvier 2003 au 31 décembre 2003 et Statistiques sur les Réalisations de DISC.

DGL Felo, ***La Gestion de la santé en tant que compétence transférée Module de formation***, Janvier 2004, DGL Felo pour ARD, Inc., Janvier 2004.

DGL Felo, ***Santé Du conseil Municipal et du Conseil Rural***, DGL Felo pour ARD, Inc., Juin 2002.

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Family Health International, ***Programme de Prééet de Traitement des IST/VIH/SIDA, Rapport d'activités Janvier – avril 2004***, Accord de Coopération USAID/FHI No. 685-A-00-00-00102-00.

Family Health International, ***Programme de Prééet de Traitement des IST/VIH/SIDA, Rapport annuel d'activités 2003***, Accord de Coopération USAID/FHI No. 685-A-00-00-00102-00.

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Family Health International (FHI), ***RAPPORT D'ACTIVITES OCTOBRE 2000 – MARS 2001 FHI, Mars 2001***.

Groupe SERDHA, ***Enquête dans 15 Districts sanitaires des régions de Fatick, Kaolack, Louga et Thiès***, Rapport Final, version anglaise, Etude financée par l'USAID, October 2003.

Merritt, Gary and Oumar Ndiaye, ***USAID/Senegal Health Portfolio Assessment July – September 2002***, Population Technical Assistance (POPTech) Project Assignment Number 2002-062, September 2002.

Ndoye, Col. Adama, et. al., ***NEW BORN HEALTH INTERVENTIONS IN SENEGAL THE EARLY IMPLEMENTATION PHASE***, report produced by the Ministry of Health, Hygiene, and Prevention and BASICS II under USAID financing, draft September 30, 2004.

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Pollock, John; Malcolm Bryant, John McKenney, and Amelie Sow, **Senegla Maternal Health/Family Planning Project (SM/PF) Interim Assessment**, Dakar, November 3-21, 2003.

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U.S. Agency for International Development, Bureau for Policy and Program Coordination, ***U.S. Foreign Aid Meeting the Challenges of the Twenty-first Century***, January 2004.

USAID/Senegal ***Country Strategic Plan 1998-2006***, as Revised: June 1998, plus ***Addendum 5: USAID/Senegal Strategic Objective 3, Illustrative National Level Interventions***.

USAID/Senegal, ***2002 Annual Report Part II***, March 4, 2002.

USAID/Senegal, ***Annual Report FY 2003***, January 6, 2003.

USAID/Senegal, ***Annual Report FY 2004***, December 19, 2003.

USAID/Senegal, ***Annual Report FY 2005***, January 12, 2005.

The GOS and the donors, including USAID, are working to address the notable residential disparities in the health status of urban and rural populations in Senegal.

The eight year (FY 1998-2006) USAID/Senegal Health strategic Objective numbered 685-309 and titled “increased use of decentralized health services in targeted areas” aims at supporting the goals and objectives of the Government of Senegal (GOS) 1997-2007 National Plan for Health and Social Development. The intervention areas include 150 communities in 22 health districts in five (out of 11) regions of Senegal. The activities relate to five technical domains: Child Survival (including malaria), maternal Health /Family Planning; Sexually Transmitted Diseases/HIV -AIDS; Tuberculosis; and Health Financing.

To implement the activities USAID/Senegal awarded contracts, cooperative agreements, and grants to 15 implementing partners that, in turn, collaborated with numerous public offices, NGOs, private commercial entities, local governments, and community actors throughout Senegal. USAID/Senegal and its partners have (1) nurtured community-local government-health service joint planning and budgeting; and (2) collaborated with public health authorities to (2.a) provide training and formative supervision, (2.b) integrate numerous service strategies into public health norms, and (2.c) expand access to these new strategies to many health facilities in the focus districts. The budget has increased over time due to availability of additional funds for HIV -AIDS, malaria, and tuberculosis. 55% of the funding has been allocated to the local level and 45% of resources to national services and systems.

This assessment was conducted by Ms. Laura McPherson from Caribbean Resources International (CRI) Consult, Inc. The assessment methods and approaches include review of documents, in-briefings, joint work sessions with the Health Team of USAID/Senegal (commissioner), meetings with key stakeholders, key informant interviews, and field trip. The first joint work session with the commissioner helped to (a) develop mutually agreed work plan; (b) review and confirm the planned dates of submission of deliverables, review process of the deliverables, list of contact persons, sites to visit, and appointment dates and times; and (c) brainstorm on key accomplishments, weaknesses, opportunities, and threats for the Health Strategic Objective.

The purpose of the assessment was to help (1) USAID/Senegal to determine whether its efforts in the health sector have been productive and successful, and (2) to guide the development of new directions in the next phase of USAID assistance to Senegal. Table below summarizes the major findings, conclusions, lessons learned, and recommendations.

FINDINGS	CONCLUSIONS	RECOMMENDATIONS	LESSONS LEARNT
There are mechanisms for collaboration and joint efforts between and among the partners.	The relationships are strong across the portfolio at all levels. The levels are certainly appropriate for week-to-week and month-to-month management needs. However, there are occasional needs for high-level discussions on specific issues. Furthermore, there is an appealing need to collaborate more with other USAID/Senegal SOs and other donors for more synergy and continued funding of USAID current partners.	1. Establish some working relationships with higher ranking officials of the Ministries of Health, Decentralization, and Economy/Finance. 2. Work also with other donors, as appropriate to pursue similar complementarities over time. 3. Provide guidance and incentives to assure coordination and synergies in the next strategy.	In hindsight, more attention to critical linkages between the local and national levels might have led to better communications between those levels, and more widespread results.
Management successes have been greater with services delivery than with systems support in spite of the increase in the budget allocation to the latter (25% to 45%).	The “right mix” depends to a great extent on the activity, strategy, and/or objectives.		
There are mechanisms to solicit and respond to the expressed needs of communities and local governments.	Mostly, the intent of the “demand-driven” Country Strategic Plan was met.		
Overall the intended expected results were achieved as shown by the scanty supporting documents available.	Periodic external evaluations and more analytic documentation of results help to manage for results. The lack of documentation makes difficult the dissemination of the results or the inference or demonstration of impact.	1. Do district specific analyses of DHS data to isolate the impact of USAID assistance through empirical evidence of success. 2. Conduct more topical and qualitative evaluations.	
The decision of major donors to provide budget support will increase central revenue flows	USAID does neither need to set aside money for public sector operations, nor need to consider non project assistance given its current high disbursement rate.	May consider offering technical assistance to help the Ministry of Health to disburse efficiently the funding expected from the budgetary support and HIPC.	
USAID has positively impacted norms and protocols.	Bear in mind that policy implementation is not linear, and this should be factored when setting targets.		

FINDINGS	CONCLUSIONS		RECOMMENDATIONS	
The majority of informants stated that there was good two-way communication and involvement. This is critical for sustaining the fragile and tenuous technical gains.	Sustainability of gains depends on factors including quality of community provider, and continued presence or engagement of supervisors, NGOs, and other partners.		Consider building greater capacity at the regional level to reengage regional personnel and foster their involvement. Attempts to strengthen capacity at the local level should be accompanied by an early and explicit strategy.	
In graduated districts from the Matching Grant, local governments are still making health plans and budgeting by their own, and are making financial contributions.	Progress on the implementation of Health decentralization is encouraging.		Undertake an external evaluation of local planning and budgeting experience. The evaluation team must include a decentralized health care specialist. For future consideration, decentralization should be a cross-cutting theme.	
Women are quite well involved whereas men, in areas like FP, are poorly involved.	The women's participation in planning, implementation, and monitoring balances their absences in being heads of rural posts and communities.		<ol style="list-style-type: none"> <li>1. Continue to consider "men as partners/parents" for RH.</li> <li>2. Continue to work with mother's and grandmother's clubs regarding maternal health.</li> </ol>	
The selection of intervention areas was driven by pre-existing relationships.	Staying in the same areas helps to build on past experience and likely leads to efficiency.		Consider including "pre-existing relationships" into the list of selection criteria for a future strategy. This might not make sense if routine service delivery is no longer supported. Withdrawing from support to routine services and focus would translate into gradual phase out of focus districts. Then, consider addressing the technical domains on "market segmented" or "population segmented" basis.	
There is evidence that over half of the population is under 20 years of age, and the adolescents are sexually active singles, couples, and parents.	The adolescents merit some future focus.		Continue to work with youth to maximize achievements.	
Mostly, Catholic mission facilities, among the non-profit private sector, provide direct health services, even though new community-based entities started implementing activities.	The innovative contracting of new community-based entities like ARPV has important implications for sustainability. Chance for similar institutional innovations may arise and should be investigated.	Private providers and supporters are key actors in Senegal's health networks.	Continue to collaborate with both international and national non-profit private sector.	Work with private sector on an equal, strategic and deliberate basis as public sector.
Most of the current SO3 partners work with commercial private sector at some level.			Collaborate with the public health authorities to assure the quality of the expanded scope of services provided by the commercial private sector.	
Mostly, private health care support has been given to individual and regional mutual organizations.			Continue the strengthening of mutual organizations as well as other insurance and pre-payment schemes. This implies, inter-alia, readjustment of resource allocations to proportionately reduce funding for Access and Demand.	